HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

Administrator's Digest

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ay Amberg (see page 5)

The News Magazine for Hospitals

AUGUST | 1958

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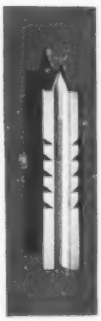

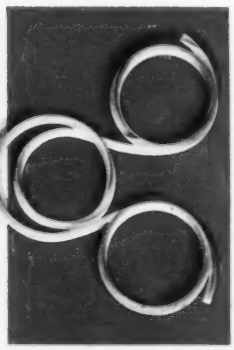

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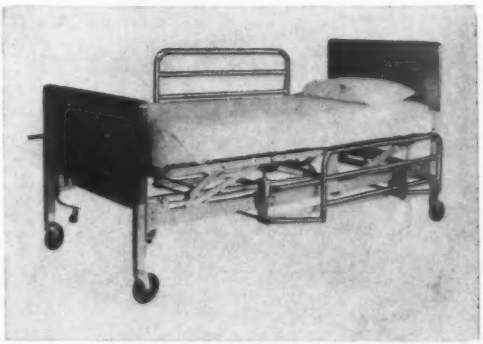

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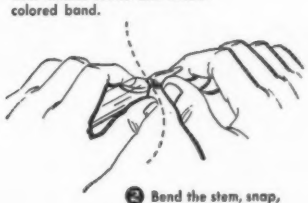

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PERSONALITY OF THE MONTH

President-elect of the American Hospital Association Ray Amberg was born in Minnesota and has devoted most of his adult years to advancing that state's standing in the field of public health.

For 25 of these years, he has worked actively with the state legislature to raise funds and to improve licensing laws both for hospitals and for administrators. So outstanding have been his contributions to the health field, however, that he is known, and has been signally honored, throughout the country.

Now director of the University of Minnesota Hospitals, Mr. Amberg began his hospital career after graduating from the university with a degree in pharmacy in 1920. While working as a hospital pharmacist, he continued his studies and in 1924 became an assistant manager of the university hospitals. He advanced to manager in 1929 and in 1935 became superintendent and director.

In addition, he has been a professor of hospital administration in the university's School of Public Health since 1946. From 1945-49, he was chairman of the federal hospital survey and construction program.

Mr. Amberg has been a member of the U.S. Pharmacopeia Revision Convention; Governor's Committee on the Handicapped; Committee on Hospital Survey; Minnesota State Subcommittee on Aid to Nursing Education; Advisory Committee to State Board of Health on Hospital Licensure; and State Board of Health Committee on Registration of Hospital Administrators.

He is a charter fellow of the American College of Hospital Administrators, and has served as both regent and vice-president of the college. He served as president of the Minnesota Hospital Association, and as chairman of its committee on government relations; and as president, Minnesota Tuberculosis and Health Association.

He will take office as president of the AHA when it meets in Chicago this month. Previously he has served as an AHA trustee, a member of its House of Delegates, and as trustee of the Council on Professional Practices.

Among Mr. Amberg's many honors are the Minnesota Newman Club award and the Harrington Public Health award.

He is married to the former Rose Ann Keogh. They are the parents of two children: John Raymond, an M.D., and Mrs. Harold M. Kelly.

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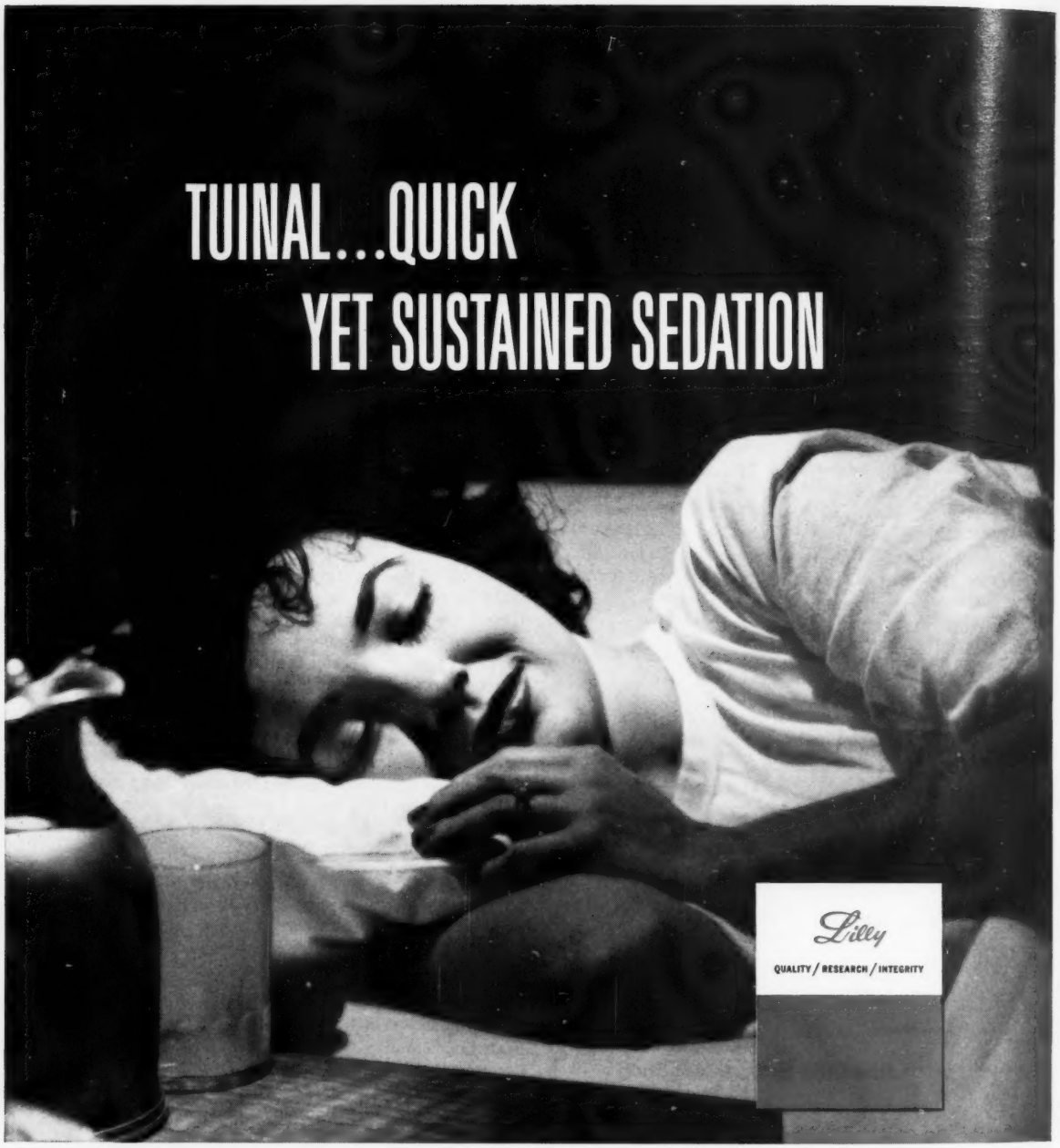

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HOSPITAL Topics
The News Magazine for the Hospital Staff

AUGUST, 1958
VOL. 36, NO. 8

Scanning the News

Spinach Isn't All It's Cooked Up to Be

Confirming young frys' nonerudite conclusions, spinach has been generally overrated, according to William Bolton, M.D., associate editor of *Today's Health*.

Fact is, it contains less iron per portion than potatoes, squash and carrots, he points out. A low-calorie, "filling" food, it's good for dieters and, Dr. Bolton concedes, "can be a tasty side dish" if properly prepared.

Important Breakthrough in Cancer Research Reported

Samuel Graff, M.D., professor of biochemistry, Columbia College of Physicians and Surgeons, New York City, disclosed at a recent meeting of cancer experts the development of a highly intricate apparatus which permits continuous cell culture outside the animal body.

Called a "continuous regulated cytogenerator," the device now gives investigators a near-faithful duplication of the animal body cavity, in which all mechanisms involved in the growth of cancer can be regulated and studied in complete isolation.

Experiments utilizing both radioactive and stable isotopes in the cytogenerator, which is roughly the mechanical equivalent of a heart, lung, and kidney, have already demonstrated not only the wasteful, voracious appetite of cancer cells, but also their relative independence from normal regulatory hormonal controls.

It is anticipated that such studies will help detect characteristic inherent flaws in cancer cells against which therapy can be designed.

In new Cincinnati, Ohio, laboratory devoted to typing staphylococcus cultures for antibiotics resistance and bacteriophage type, Mrs. Marian Thomas (seated), bacteriologist, demonstrates sample culture to Robert D. Southwick (l.), administrator, Children's Hospital, Cincinnati, Carl A. Wilzbach, M.D., Cincinnati Health Commissioner, and Sister Eugene Marie, administrator, Good Samaritan Hospital, and president, Greater Cincinnati Hospital Council. Lab is a joint venture of the hospital council, the Cincinnati and Ohio Health Departments, and the U.S. Public Health Service. Housed at the Robert A. Taft Sanitary Engineering Center of the PHS, the unit serves southern Ohio, northern Kentucky, and southeastern Indiana. On its first day, the new lab got a unique special assignment: type the staphylococci isolated from an eight-year-old lion which had died at the Cincinnati Zoo. Since the strain turned out to be type 42-B, usually found in humans, three lion house keepers are undergoing tests to see if they are carriers.

Influenza Virus Pneumonia Held to be Distinct Entity

Findings suggesting that primary influenza virus pneumonia may be a distinct, clinically definable entity with features differing from secondary bacterial pneumonia were presented by David E. Rogers, M.D., associate professor of medicine, New York Hospital-Cornell Medical Center, New York City, at the recent annual meeting of the Association of American Physicians.

Clinical, microbiologic, and pathologic studies of 30 patients at New York Hospital during the recent Asian influenza epidemic indicate that influenza virus may have been the sole infectious agent in the deaths of six of these patients, he noted. All of these patients had evidence of preexisting heart disease.

The lungs of four patients contained higher concentrations of influenza virus than did the lungs of patients dying with bacterial pneumonia associated with influenza. Three of the four positive specimens showed concentrations of infectious virus ranging from 20 to 2,000 times the concentrations observed in lungs from which staphylococci and influenza

(Continued on page 14)

News Briefs at Press Time

CONGRESS APPROVES $150 MILLION FOR HILL-BURTON CONSTRUCTION

Both Senate and House have approved bill calling for $150 million—top limit permissible—for this year's Hill-Burton appropriation for construction of acute beds.

Additional $35 million was appropriated for construction under Part G of H.-B. Act —$7½ million for chronic-disease facilities, $7½ million for diagnostic and treatment centers, $10 million for nursing homes, and $10 million for rehabilitation centers.

Extension of Hill-Burton program, which expires next year, has also been approved by Senate and House, but for different periods. Senate passed five-year extension; House approved three-year extension. Agreement will have to be reached in committee.

DRASTIC BUDGET CUTS SOUGHT FOR 1959; POSSIBLE WAR CONTROLS BEING DEVELOPED

Budget experts, working on 1959-60 federal budget, believe recession is over, and are aiming at large cutbacks. They're incensed over $14 billion deficit for fiscal year which ended June 30.

At least six agencies are working night and day on wartime restrictions. State Department does not believe war will develop. The military are not so optimistic. Full government controls are being readied—just in case.

SENATE APPROVES $75 MILLION FOR LOANS FOR STUDENT NURSE HOUSING

Omnibus housing bill passed by Senate includes $75 million this year for loans for construction of housing for interns and for student nurses in hospital schools. This is an increase of $50 million over present appropriations, but only half the amount requested by AHA.

Community facilities loan bill (Fulbright bill) has passed the Senate. However, even if it passes the House, it will probably be vetoed. Bill would provide for low-interest loans to municipalities and voluntary hospitals.

Several other hospital loan bills authorizing administration by PHS have been introduced but will probably be bottled up.

NAVY REQUEST FOR $8 MILLION FOR MEDICARE DEFICIT DENIED

Navy's request for $8 million to pay Medicare bills has been denied by House appropriations committee. In denial, committee charged that behind request probably lies a violation of federal law prohibiting officials from obligating unappropriated funds.

Committee report implied that deficit occurred because Navy did not heed warning a year ago to promote greater utilization of military treatment facilities and spend less money on Medicare services.

Meanwhile, AMA, AHA, National Medical Veterans' Society, and California Medical Association testified before a Senate subcommittee in opposition to proposed curtailment of privileges of military dependents to choose between private and government medical and hospital facilities. Free choice is an issue in Defense Department appropriations bill.

Subcommittee is expected to delete $60 million Medicare ceiling from bill but insert instructions to Defense Department to use military medical facilities to the optimum.

BRIEF BRIEFS

Conference on staphylococcal diseases will be held September 15-17 at PHS Communicable Disease Center in Atlanta . . . PHS, Office of Education, and Children's Bureau are recommending that state and local governments consider substitution of tuberculin skin tests for x-rays in initial screening for detecting tuberculosis among students and school employees . . . TOPICS staff members hope to see you at the AHA convention in Chicago this month. Please stop to say hello at booth 624.

Gordon M. Marshall

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Calendar of Meetings

AUGUST

4- 8 American Osteopathic Hospital Association, Medical Record Librarians Training School, University of Colorado, Boulder

15-20 World Medical Association, Copenhagen, Denmark

16-18 American College of Hospital Administrators, Annual Meeting, International Amphitheatre; Convocation, Orchestra Hall, Chicago

18-21 American Hospital Association, International Amphitheatre, Chicago

24-29 American Congress of Physical Medicine and Rehabilitation, Philadelphia

SEPTEMBER

7-11 American Surgical Trade Association, Shoreham Hotel, Washington, D.C.

8-12 AHA Institute, Dietary Department Administration, Bellerive Hotel, Kansas City, Mo.

9-10 AWH Workshop on Public Relations, Boise, Idaho

12-13 AWH Institute on Hospital Accounting, Hotel Multnomah, Portland, Ore.

15-16 AWH Workshop on Supervisory Training, Olympic Hotel, Seattle

15-16 Montana Hospital Association, Elks Club, Havre

15-17 AHA Institute, Disaster Planning, Adolphus Hotel, Dallas, Tex.

18-19 American Osteopathic Hospital Association, Northwest Institute, New Heathman Hotel, Portland, Ore.

22-25 AHA Institute, Evening and Night Nursing Service Administration, Sheraton-Lincoln Hotel, Indianapolis

25-26 AHA Institute, Hospital Insurance, Capitol House, Baton Rouge, La.

26-27 American Medical Writers' Association, Hotel Morrison, Chicago

28-Oct. 1 American Fracture Association, Oklahoma City, Okla.

29-Oct. 2 AHA Institute, Operating Room Administration, Sheraton-McAlpin Hotel, N. Y.

29-Oct. 2 AHA Institute, Medical-Social Workers, Hotel Radisson, Minneapolis

OCTOBER

2- 3 AWH Institute, Improvement Through Forms, New Concepts of Departmental Management, Surf Rider Inn, Santa Monica, Calif.

6-10 American College of Surgeons, Conrad Hilton Hotel, Chicago

8- 9 Indiana Hospital Association, Indiana University Student Union Building, Indianapolis

8- 9 Vermont Hospital Association, Hotel Vermont, Burlington

9-10 AWH Institute, Housekeeping, Food Service, Maintenance, Hotel Hilton, Albuquerque, New Mexico

12-17 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

13-16 American Association of Medical Record Librarians, Statler Hotel, Boston

15-16 Washington State Hospital Association, Winthrop Hotel, Tacoma

(Continued on page 12)

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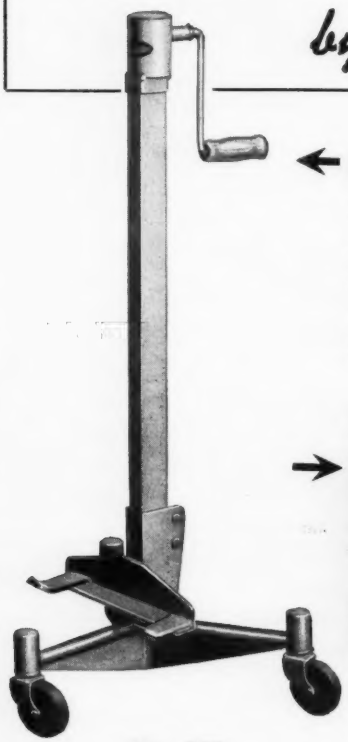

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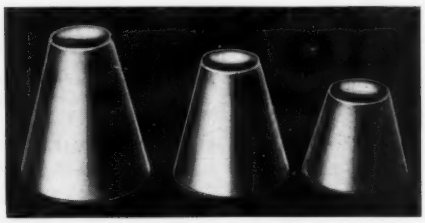

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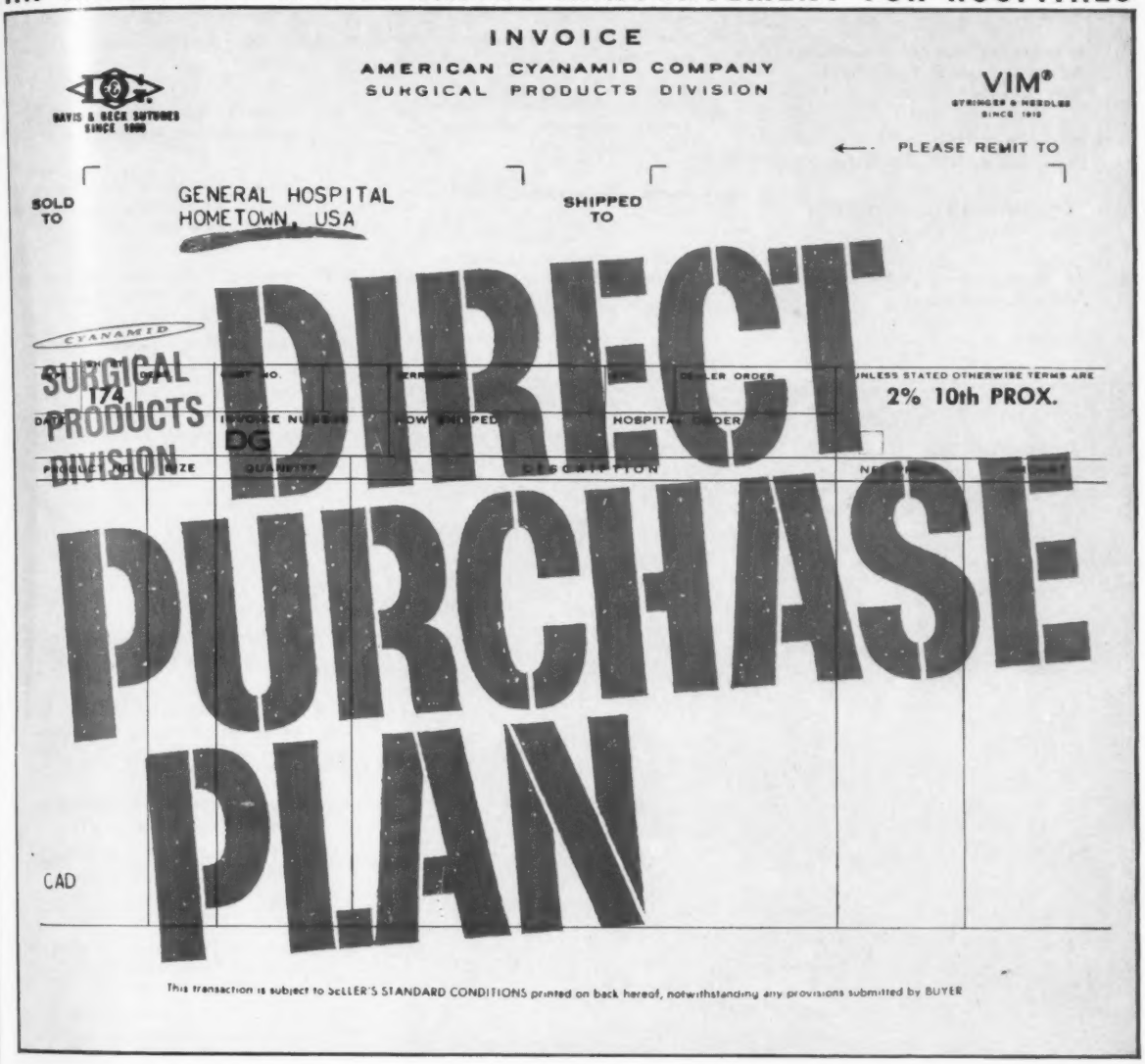

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CALENDAR OF MEETINGS

(Continued from page 10)

15-17 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask., Canada

16-18 West Virginia Hospital Association, Daniel Boone Hotel, Charleston

20-21 Idaho Hospital Association, Hotel Boise, Boise

20-23 American Academy of Pediatrics, Palmer House, Chicago

20-24 National Safety Council, Conrad Hilton Hotel, Chicago

21-23 American Dietetic Association, Trade and Convention Center, Philadelphia

21-23 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alb., Canada

21-24 American Society of Anesthesiologists, Penn Sheraton Hotel, Pittsburgh

22-24 California Hospital Association, Biltmore and Miramar Hotels, Santa Barbara

23-24 Mississippi Hospital Association, Hotel Heidelberg, Jackson

23-24 Nebraska Hospital Association, Omaha

24-28 American Heart Association, Civic Auditorium, San Francisco

25 American College of Osteopathic Hospital Administrators, National Institute, Statler Hotel, Boston

26-29 American Osteopathic Hospital Association, Statler Hotel, Boston

27-31 American Public Health Association, Kiel Auditorium, St. Louis

28-31 British Columbia Hospital Association, Vancouver Hotel, Vancouver, B.C., Canada

31 AHA Financial Institute, Portland, Ore.

NOVEMBER

1- 8 American Society of Clinical Pathologists, Congress Hotel, Chicago

3- 5 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

6- 7 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

7 Minnesota Hospital Association, Lowry Hotel, St. Paul

10-13 Interstate Postgraduate Medical Association Assembly, Public Auditorium, Cleveland, O.

10-14 American Association of Inhalation Therapists, Kingsway-Ambassador Hotel, St. Louis

12-14 AWH Institute on Hospital Administration and for Hospital Auxiliaries, Princess Kaiulani Hotel, Honolulu, T. H.

13-14 Arizona Hospital Association, Westward-Ho Hotel, Phoenix

13-14 Kansas Hospital Association, Baker Hotel, Hutchinson

14-16 Virginia Hospital Association, Hotel Roanoke, Roanoke

16-20 National Society for Crippled Children and Adults, Statler-Hilton Hotel, Dallas, Tex.

17-18 International College of Surgeons, Mid-Atlantic Meeting, Homestead Spa, Hot Springs, Va.

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(Continued from page 7)

virus were recovered. These concentrations approach those observed in the lungs of experimental animals dying with pure influenza virus pneumonia.

This illness, concluded Dr. Rogers, "may assume relative importance if bacterial pulmonary infections associated with influenza can be partly controlled by the anti-microbial drugs."

Mouth-to-Mouth Breathing Best Resuscitation Method

Mouth-to-mouth breathing, oldest known resuscitation technic, is "unequivocally superior" to manual technics, in all age groups, according to comparative experiments by Archer S. Gordon, M.D., and associates, University of Illinois College of Medicine, Chicago.

Their findings, reported in the May 17, 1958, issue of *The Journal of the AMA*, indicate that only the mouth-to-mouth technic assures that an adequate volume of air will enter the victim's lungs. Work of three other research teams on the method was reported in the same issue; the series was published under the auspices of the AMA Council on Medical Physics.

On the basis of these reports, the council plans to revise its resuscitation pocket instruction card.

New Emphysema Therapy Enlists Patients' Help

A new treatment for emphysema, in which a permanent tracheocutaneous fistula is created, and in which patients themselves utilize tracheobronchial aspiration with special catheters, was described recently by a team of physicians at the annual convention of the Medical Society of New York.

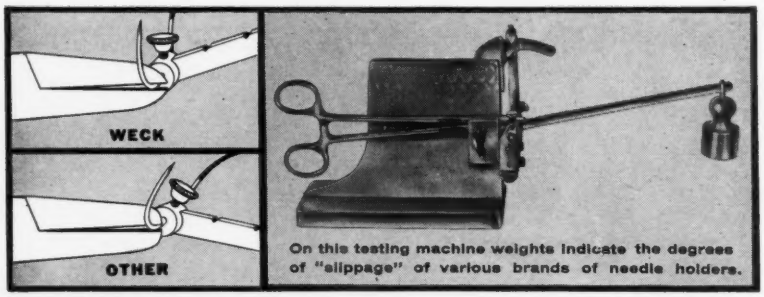
The operation—tracheal fenestration—has been performed on eight patients. In four of these, discussed in detail, two received some palliative relief, and two were rehabilitated sufficiently to leave the hospital. All eight patients easily learned to insert their own catheters into the right or left lung.

Team members are Samuel A. Thompson, M.D., director, department of thoracic surgry, and Edward E. Rockey, M.D., both of Metropolitan Hospital; Edgar Mayer, M.D., University Hospital; Israel Rappaport, M.D., Bellevue Hospital Center; and Charles F. Blazsik, M.D., Manhattan General Hospital, all in New York City.

X-Ray Exam Psychological Lift to Back Sufferers

James K. Stack, M.D., reports in a recent issue of *Radiology* that the use of x-ray equipment during the examination often has a beneficial effect in allaying a patient's concern about that nagging pain in his lower back.

The patient whose back examination has been limited to the loosen-your-belt-and-pull-up-your-shirt variety "is indeed comforted in the x-ray department because he feels that for the first time," says Dr. Stack, "he is getting a real examination."



On this testing machine weights indicate the degrees of "slippage" of various brands of needle holders.

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Above diagrams explain the action of the testing machine at the right. Upper diagram shows how the Weck "Bulldog" jaw holds the needle rigidly, resisting the "pull" of the weight on the bar. Lower diagram shows how the jaws of leading competitive holders permit the needle to slip as indicated by the lowering of the bar.

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The latest in the line of Weck "Bulldog" Jaw Needle Holders is the sensational new "Ryder" (at right) which also boasts these two exclusive features:

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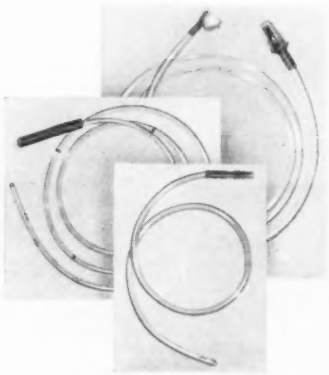

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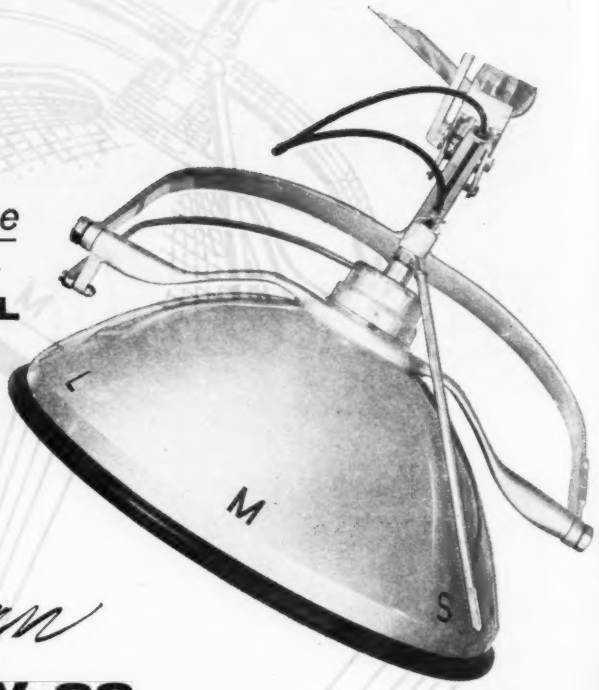

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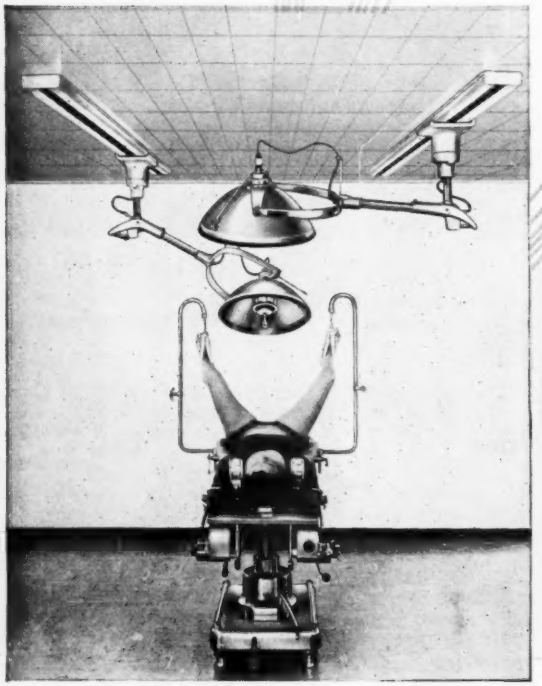

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Convention Capsules

Preview: 60th Annual AHA Convention

- OUTSTANDING SPEAKERS
- VARIED DISCUSSIONS
- FILM PROGRAM
- TECHNICAL EXHIBITS

Chicago's International Amphitheatre will become the focus of what is new and timely in the hospital world when the 60th annual convention of the American Hospital Association meets there August 18-21.

Offering a widely varied program of conferences, lectures, idea-exchange sessions, and technical exhibits, the meeting is expected to draw over 12,000 hospital and health personnel from throughout the U. S. and Canada. New features of the program this year reflect the broadened scope of hospital responsibility and interest. On Monday afternoon, a three-hour session has been planned to provide an idea exchange for directors of hospital volunteers. Wednesday has been designated as "Trustee Day."

Opening the program will be the dedication of the new AHA building at Lake Shore Drive and Pearson St. in Chicago. At 11:15 a.m. Monday, ceremonies will be piped from the lobby of the new building over closed circuit television to the convention registrants at the Amphitheatre.

Again this year the program will offer the popular symposium on management sessions initiated last year. Also featured will be daily conferences on hospital planning and a total of more than 40 roundtable type meetings termed, this year, "Instructional Conferences."

Highlight of the annual banquet Wednesday evening will be presentation of the 1958 Distinguished Service Award to John N. Hatfield, director, Passavant Memorial Hospital, Chicago, and treasurer of the AHA. Honorary membership awards will be given to Lowell T. Coggeshall, M.D., dean, division of Biological Sciences, University of Chicago; Edward C. Logelin, vice-president, United States Steel Corp., Chicago; and J. Roscoe Miller, president, Northwestern University, Evanston, Ill.

Allied groups meeting during the convention include: American College of Hospital Administrators, August 16-20, with the annual convocation scheduled for August 17, at Orchestra Hall, Chicago; American Association of Hospital Consultants, August 16, August 19; American Association for Hospital Planning, August 16-17, August 19; and American Association of Nurse Anesthetists, August 17-21.

The Program in Brief

Monday, August 18

11:15 a.m.—Dedication of AHA building, Tol Terrell, president, AHA, presiding

12:00-2:00 p.m.—Luncheon for international guests

2:00-5:00 p.m.—Special Session: "Idea Exchange for Directors of Hospital Volunteers—Principles, Programs, Progress"

2:15-3:00 p.m.—General Assembly: "International Affairs," James Hopkins Smith, Jr., director, International Co-operation Administration, Washington, D.C.

3:15-4:30 p.m.—Symposium on Management: "The Hospital—Planned Growth or Stagnation"; "The Application of Principles of Organization to Planning"

3:15-4:30 p.m.—Concurrent Session: "Project Parade"

3:15-4:30 p.m.—Instructional Conferences
Engineering: "New Ideas for Hospital Building Maintenance"
Personnel: "Setting Up an Inservice Training Program"
Professional Practice: "Hospital Units by Levels of Care"; "Nursing Service Supervision and Administration"; "Sharing Professional Skills"
Public Relations: "Planning and Evaluating a Public Relations Program"

6:00-8:00 p.m.—President's reception and tea dance; children's social hour

Tuesday, August 19

9:30-10:15 a.m.—General Assembly: "The Challenge Facing Health Care Today," Hugh H. Hussey, M.D., professor of medicine, Georgetown University, Washington, D.C.

10:30-11:45 a.m.—Conference on Hospital Planning: "Hospital Facilities Utilization Study at Yale University"; "Progressive Care"

10:30-11:45 a.m.—Concurrent Session: "Youth Looks at Health Careers"

10:30-11:45 a.m.—Instructional Conferences
Accounting: "Tooling Up for Cost Control"
Dietary: "Evaluating Your Type of Food Service"

(Continued on next page)

Nursing: "Two Year Nursing School Programs"
Pharmacy: "Problem Areas in Hospital Pharmacy"
Professional Practice: "Sterilization and Chemical Disinfection in Hospitals"

12:00-2:00 p.m.—Federal Hospitals' luncheon

2:15-3:30 p.m.—Symposium on Management: "The Nature of Administration"; "Principles and Tools Alone Cannot Give Good Administration"

2:15-3:30 p.m.—Concurrent Session: "Orientation of New Auxiliary Members"

2:15-3:30 p.m.—Conference on Hospital Planning: "Operation of Hospital Planning and License Laws"

2:15-3:30 p.m.—Instructional Conferences
Hospital Infections: "Controlling Infections in Hospitals"
Nursing: "The Role of the Practical Nurse on the Hospital Nursing Team"
Personnel: "Influences on Employee Relations"
Volunteer Service: "Pilot Studies for New Volunteer Services"

3:45-4:30 p.m.—General Assembly: Speaker to be announced

Wednesday, August 20

9:30-10:15 a.m.—General Assembly "Management Looks at the Community," Erik Jonsson, chairman of the board, Texas Instruments, Inc., Dallas, Tex.

10:30-11:45 a.m.—Concurrent Session: "Hospital Accreditation"

10:30-11:45 a.m.—Instructional Conferences
Auxiliaries: "Gift Shop Management"; "Snack Bar Management"; "Auxiliary Representation on Hospital Governing Boards"
Chronic Illness: "Caring for the Long-term Patient in General Hospitals"
Engineering: "Economy in Plant Operation"
Nursing: "Nursing School Accreditation Program"
Planning: "Development of the Master Plan for a Metropolitan Area"
Purchasing: "Hospital Products and Equipment of the Future"

11:45 a.m.—Exhibit Awards

12:15-1:45 p.m.—Hospital Auxiliaries' luncheon

2:15-3:30 p.m. — Symposium on Management: "Hospital Costs—A National Review"; "The Unique Aspects of Administration in a Social or Community Organization"

2:15-3:30 p.m.—Concurrent Session: "Volunteer Talent Pays Off"

Visit HOSPITAL TOPICS at Booth 624

2:15-3:30 p.m.—Instructional Conferences
Accreditation: "Hospital Accreditation Problem Clinic"
Fund Raising: "Steps in Formulating a Fund Raising Program"
Insurance: "Claim and Suit Prevention"
Professional Practice: "Trustee-Administrator-Medical Staff Relations"
Volunteer Service: "Organizing a New Volunteer Service in the Small Hospital"; Responsibilities of the Director of Volunteers"

3:45-4:30 p.m.—General Assembly: "Human Resources: The Wealth of a Nation," Eli Ginzberg, Ph.D., professor of economics; director of Conservation of Human Resources and of staff studies, National Manpower Council, Columbia University, New York City

6:00 p.m.—Reception and banquet

Thursday, August 21

9:30-10:15 a.m.—General Assembly: "Humanities," Joseph N. Welch, senior partner, Hale and Dorr, Boston

10:30-11:45 a.m.—Concurrent Session—It Worked for Us: "A Plan to Overcome Our Personnel Shortage Which Works"; "The Mental Hospital and the Medical Community"; "Telling Our Hospital Story"; "Is There an Equivalent for the Full-time Chief of Staff Concept"; "Establishing a Free Clinic in a Rural Hospital"

10:30-11:45 a.m.—Instructional Conference
Disaster: "How to Develop a Hospital Disaster Plan"
Laundry: "New Ideas for Laundry Operation"
Medical Education: "Screening Program for Graduates of Foreign Medical Schools"
Professional Practice: "Alcoholism"; "Hospital-Nursing Home Relations"
Public Relations: "Press Relations—Privacy of the Patient"
Rehabilitation: "Rehabilitation as a Service in a Community Hospital"

12:00-2:00 p.m.—Sisters' luncheon

2:15-3:30 p.m.—Symposium on Management: "Conformity Can Be Stimulating"; "Flexibility Can Be Created Within a Formal Organizational Structure"

2:15-3:30 p.m.—Instructional Conferences
Medical Education: "Clinical Pathology Training Programs in Hospitals"
Nursing: "Nursing Utilization Studies"
Physicians' Offices: "Pros and Cons of Physicians' Private Offices at Hospitals"
Planning: "Converting an 1898 Hospital into a 1958 Hospital"
Professional Practice: "Medical Audit"
Purchasing: "Standardization of Hospital Equipment and Supplies"
Radiation: "What the Hospital Administrator Should Know about Radiation"

Catholic Hospital Association --

Atlantic City, June 22-26

Point of View

Supervisor Should Be Link Between Head Nurse, Director of Nursing

Nursing today has become complex in all phases, perhaps most complex in the administration of service. The director of nursing service is no longer master of all she surveys; she is engaged in democratic processes of operation from day to day. It is no longer possible for her to wield an intimate control over every situation; hence the need has arisen for assistants who are a step closer to the patient care units.

The level of the supervisor is between that of the head nurse and that of the director of nursing service; she serves as an assistant to the latter, and has three main functions: administration; personnel development; service to the patient.

She should share communications of a two-way nature with the director to facilitate the discussion of nursing situations, needs, plans, programs, and problems affecting the patient. In her function as intermediary between the head nurse and the director she should be exact in communicating proper information, in seeing that specified forms for reports from nursing service units are sent to the proper authorities at the right time.

On the nursing unit, the assistant may stimulate the head nurse to apply principles of good ward management, and help her in solving problems.

A study by Chris Argris, associate professor of industrial administration, Yale University, revealed these five characteristics common to most nurses:

1. Indispensable-minded, with a desire to be needed for their warmth and skills.

2. Self-controlled.

3. Harmonious, sensitive to others' needs; tend to minimize conflict.

4. Self-responsible; dislike close supervision.

5. Passive; dislike to direct others.

A nurse promoted to head nurse or assistant to the director will tend, then, to have certain failings:

1. A dislike to check up on others, to penalize.

2. A tendency to go to great lengths to avoid upsetting others.

3. An inclination to perform details herself.

4. A tendency to use an indirect approach in giving directions.

5. A tendency to put the blame on circumstances or policies when assigning undesirable tasks.

Many times the assistant will be uncertain of herself in administrative duties, and will ease her insecurity by performing herself some of the head nurses' administrative duties. This is not acceptable nor in keeping with her own responsibilities. Further, if the head nurse is absent, her duties should be delegated to another staff nurse.

Planning to continue an educational program for the staff in her area is the assistant's responsibility. She can foster initiative by encouraging personnel to offer suggestions, and, in turn, inter-

(Continued on next page)

First prize in the annual Monsignor Healy Awards for small hospitals—a monstrance for its chapel—went to St. Joseph of the Pines Hospital, Knollwood, Southern Pines, N.C. It was accepted by Sister M. Virginia, administrator of St. Joseph's.

The Rt. Rev. Msgr. F.M.J. Thornton, outgoing CHA president, awarded second Healy prize, a ciborium, to St. John's Hospital, San Angelo, Texas. In the absence of Sister Dionysia, the hospital's administrator, it is accepted by Sister M. Nicholas, St. Anthony's Hospital, Amarillo, Texas.

New CHA officers for 1958-1959, l. to r., Rev. Patrick J. Frawley, director of the division of health and hospitals, Catholic Charities of the Archdiocese of New York, first vice-president; Rev. Patrick Riley, director of hospitals for the Diocese of St. Cloud (Minn.), second vice-president, and Rt. Rev. Msgr. A. C. Dalton, director of Catholic Hospitals of the Archdiocese of Boston, president.

preting policies to them on their level of understanding.

Good nursing service is the result of good administration, which creates satisfied, efficient personnel. The assistant who maintains a close working relationship with both her head nurses and her director of nursing service will not fall short of her goal.—*Sister Marie Gabrielle*, supervisor of pediatrics, Mount Carmel Mercy Hospital, Detroit.

Facing the Future

Modern Hospital Must Face Facts To Find Its Place in Changing Era

If the role of the modern hospital in a changing era is to be properly assessed, those concerned must face some hard cold facts. Some of these facts are:

——Hospital service is the country's fifth largest industry, with physical assets totaling an estimated 13 billion dollars. While this is impressive, the mere size is no guarantee it is sufficient for present or future needs.

——If present investments are to be maintained and improved on a voluntary nonprofit basis, philanthropic giving must continue, and the modern hospital must gear itself to a sound financial structure.

——The high cost of hospital care has become of intense interest to labor, industry, government, prepayment plans and commercial insurors. If hospitals can co-operate with these groups in providing care, such interest is highly desirable. However, it is a common responsibility of all those working in the health field to guard against unnecessary utilization of hospital facilities.

——As the trend toward preventive medicine, early diagnosis, and ambulatory therapy extends, the need for technical facilities will increase. Hospitals are beginning to realize the potential possibilities of adapting outpatient care to modern medicine, reducing the length and cost of hospitalization.

——Prepayment plans now cover over 123 million people. They have helped finance day-to-day hospital care, but only to a limited degree have they made funds available for improving or maintaining physical plants. Such plans were never intended to finance hospital bed replacement or capital expansion; trustees and administrators must realize that to so use them would raise the cost of health insurance far beyond the reach of persons of moderate income.

Danny Thomas, TV and film star, spoke at the Dinner for the Religious at the convention. In a serious vein he spoke of the hospital he hopes to build in Memphis, the St. Jude Hospital for children with blood diseases. Shown with the star are three sisters from the audience of 1,000.

Hospitals will have to face up to these and other factors if they are not to be lost in a wave of change and indecision. — *The Rt. Rev. Msgr. F. M. J. Thornton*, Sea Girt, N. J., outgoing president, Catholic Hospital Association.

The Conference of Catholic Schools of Nursing, June 22-23, was opened by Dr. Marguerite Kakosh (far right), consultant in nursing, Rochelle Park, N.J. Back row: Rev. John Flanagan, executive director of CHA; Margaret Foley; Sister Camille, Mercy Central School for Practical Nurses, Springfield, O. Front Row: Sister Mary Karen, St. Joseph Hospital School of Nursing, Elmira, N.Y.; Helen Creighton, assistant professor, Georgetown University School of Nursing, Washington, D.C.; Sister Margaret Alacoque, director, School of Nursing, St. Agnes Hospital, Philadelphia; Mary Anne Hurley, clinical co-ordinator, Shelton, Conn.

Space Age

Modern Hospitals' Space Problem Is Finding Storage Facilities

The planning and layout of hospitals needs to be revised so that professional services are planned first, then communications and supply services, and finally the beds.

The flow of supplies to patients must be organized with a minimum of manpower and of waste, and a maximum of automation. It is still not unusual for a new hospital to discover that its storage space is inadequate.

Several years ago, blueprints planned by one of the country's leading consultants showed these storage facilities: a cupboard off the kitchen; a space, six feet by eight feet, off the laundry for soap and starch; a small space next to the engine room for "general" supplies; and a closet on every division for surgical supplies!

In allotting space, one should bear in mind the varieties of supplies, materials, and equipment and their individual needs as regards temperature, humidity, light, and ventilation. Since steel shelving is only one-eighth inch thick (and fireproof) in contrast to the one or one and one-quarter-inch thickness of wood, use of steel may increase storage space by as much as 12½ percent.

Since recent surveys on storage space are practically nonexistent, my hospital will serve as an example. It is close to a 1,000-bed capacity, and figures may be scaled accordingly.

A total of 28,085 square feet is reserved for storage, allocated as follows: 19,106 square feet for general usage expendable items; 6,423 square feet for such things as plumbing, painting, carpenter, and power plant supplies, trucks and yard equipment, and oxygen tents; 534 square feet for purchasing office; 742 square feet in the main kitchen for dairy and bakery products, fresh fruits, and vegetables; 700 square feet for an outside loading dock; 580 square feet for inside receiving.

The receiving function should be accomplished without any intercrossing of traffic lanes or retracing of steps. A spiral stairway will permit delivery of small packages, eliminating unnecessary use of the elevator.—*E. C. Wolf, LL.B.*, administrative assistant and director of purchases, St. Mary's Hospital, Rochester, Minn.

Forgotten Apostolate

40 Percent of Mentally Ill Recover Spontaneously; What of the Others?

How sizable is the segment of patients with acute emotional illness?

If we include the percentage with schizophrenia, manic depressive disorders, involutional psychoses, and psychoneuroses, and add 7 per cent with varied disorders including toxic psychoses, acute alcoholism, psychosomatic disorders, and situational maladjustments, we have 48.7, or about 50 percent, of the patients with psychiatric ills.

The remainder of the group is made up of those with diseases of senility, chronic, severe alcoholism, and character disorders. Ages of these patients range from 16 to 58 years; roughly 60 percent are women.

What can we offer these people? What should we offer? If nothing more than custodial care is provided, 35 to 40 percent will recover spontaneously. Medicine has accepted battles with diseases of far more crippling proportions, yet the treatment for psychiatric ailments is left to a small minority.

One pregnant mother has no difficulty obtaining private care or state care. Such is not the case for many patients with emotional illnesses. Only 11 percent of the 5,280 general hospitals in the U. S. have psychiatric units. These 584 hospitals have 25,011 beds for psychiatric patients—none of them vacant.

There are certain essentials necessary to make a psychiatric unit work in a general hospital. Principally, an administrator who can accept the challenge of psychiatric illness in the community and do something about it is necessary. Further, the unit will become successful only if it is a community project. The chief should be a qualified psychiatrist with experience in private practice, and enough community interest to make the unit more than a one-man show. He should be capable of attracting other psychiatrists to the staff so the

(Continued on next page)

An overflow audience, representing Catholic Hospital Association members from most of the 48 states and parts of Canada, attended the Pontifical Mass which marked the opening of the convention. The Most Rev. Msgr. George W. Ahr, Bishop of Trenton, delivered the sermon.

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unit also serves as a training center.—*Harold M. Manfredi, M.D.*, Loretto Hospital, Chicago.

Psychological Approach

To Guide Students to Emotional Maturity is to Gain Better Nurses

The responsibility for student development—aside from providing physical requisites—demands an active attempt on the part of all teaching or guiding personnel to relate in an integrated fashion all of the student's background factors to life goals, so that each may grow to a state of emotional security and mental maturity.

For the nursing students, such growth means development towards the fulfillment of her role as an understanding and competent nurse, personally dedicated to her profession and educated for living.

The current curriculum at St. Vincent's Hospital School of Nursing, New York City, represents a shift of emphasis from disease-centered education to patient-centered education. It provides the student not only with factual knowledge of a disease treatment but also the ability to relate technics or procedures to the patient's personality.

As the student rotates through the various training phases, psychology pertinent to the area is given concurrently. This usually includes a discussion of normal and abnormal development, and analysis of various behavior problems.

The nurse must, in a sense, also be an expert in understanding and handling human behavior. To the degree that she understands people, she will, to that extent, also be more effective as a nurse.—*Walter J. Colville, Ph.D.*, director, department of clinical psychology, St. Vincent's Hospital, New York, N.Y.

News Briefs

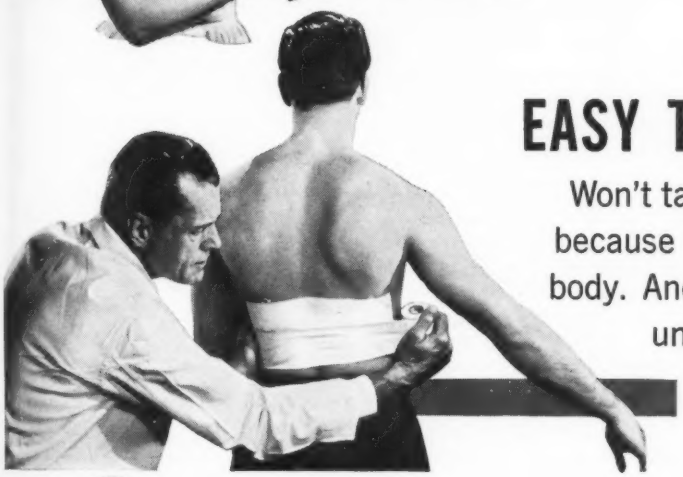
During the business session of the Conference of Catholic Schools of Nursing, June 23, delegates from 35 states unanimously approved a revision of by-laws increasing annual dues for institutional members, and adopted resolutions which reaffirm support of the three-year diploma program, recommend continued study of tuition charges, and ask for action by individual schools and by CCSN to help alleviate the faculty shortage.

It was reported that during the past year the association initiated the first continuing education program of its kind in the country—the Kellogg Foundation five-year grant to provide basic and advance training for key hospital personnel. With the association providing supplementary support from tuition fees in connection with various meetings, it has been possible to hold longer programs and to bring in experts in their field as special instructors.

THE EASY ADHESIVE

EASY TO UNWIND

Just pull gently... and new Curity adhesive unwinds easily. Clear to the end of the roll. No waste.



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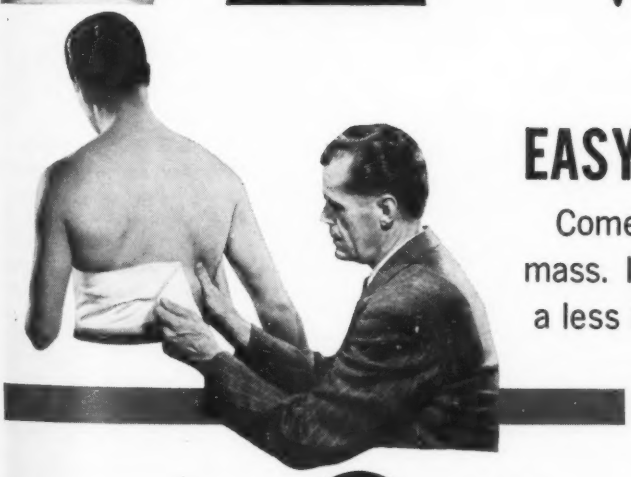
Won't tangle when you handle it, because new Curity adhesive has proper body. And it sticks and stays stuck... until you take it off.



EASY TO REMOVE

Comes off clean, leaving no sticky mass. It's kind to skin. You can't put a less irritating adhesive on a patient.

NEW Curity® ADHESIVE

Bauer & Black
DIVISION OF THE KENDALL COMPANY

Now everybody's talking...

about... *closer control of cross infection in every part of the hospital*

Wider recognition of the current problem of hospital-acquired infections is focusing new attention on ways and means of reducing this hazard to good patient care. Hospital and medical society meetings—and hospital, medical and surgical journals—are daily shedding new light on the varied aspects of the overall problem.

In many hospitals, a special "committee on cross infection" has been appointed to review practices and procedures. In others, each department head is studying closely his or her own methods of operation. Few hospitals exist which are not giving some special thought to this highly current problem.

Out of this critical evaluation has grown an awareness that environmental asepsis is a major weapon for cutting cross infection to a minimum. Application of continuous disinfection procedures from operating rooms through food service and laundry areas can be the means to changing the hospital's entire experience with hospital-acquired respiratory, intestinal, urinary or post-operative wound infections.

Take floors, for instance

Floors offer a great opportunity for furthering the spread of infection. Microorganisms settling to the floor are redispersed on dust particles or tracked through the hospital on shoes. Walls and ceilings as well can be reservoirs of potential infection. Lehn & Fink disinfectants not only kill all the most common pathogens on contact but are continuously active against new contaminants touching the disinfected surface for as long as a week later.

While the patient is there

Concurrent disinfection is practical whether or not the patient is "isolated." Wiping of furniture and fixtures and damp mopping of floor, with a disinfectant, stop air- and floor-borne microbes at the source.

In the operating room

Lehn & Fink disinfectants have many applications here. Among them: mopping floors; cleaning grills, ducts, and coils of air conditioners; as standard equipment on the scrub-up cart; as a germicidal dip to remove gross contamination from gloves before their removal; to gather instruments into enroute to sterilizer.

Other L & F disinfectant applications are many: for disinfection of instruments with lens systems, to wipe and store thermometers, to sanitize utensils, etc. In all instances, action is bactericidal, fungicidal and tuberculocidal.

Which L & F disinfectant?

Lysol®, O-syl® and Amphyl® do the same disinfecting job. Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over sixty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

And now there's Tergisyl,™ Lehn & Fink's new detergent-disinfectant, which combines superior detergency with the efficient disinfection action you have come to expect from our products.

Let's talk about it

Solving the problem of environmental infection has been the business of Lehn & Fink since 1874. Solving such problems arising in your own hospital usually takes more than talk—but perhaps you would like to discuss them with our technical specialists. We can function as a part of your "committee on control of cross infection," perhaps suggest procedures, and supply informational material for teaching purposes. At any rate, please ask us. Specially trained field service representatives as well as the technical staffs in our New York office and in our laboratories at Bloomfield, New Jersey, are available for consultation.

• • •

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SPECIALISTS IN ENVIRONMENTAL ASEPSIS
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American Physical Therapy Association--

Seattle, June 15-20

• Members of the board of directors of the American Physical Therapy Association, at the 35th annual conference in Seattle, Wash., went on record as favoring passage of physical therapy practice acts in every state.

Only 29 states now have such acts, to limit the practice of physical therapy to persons who have the proper education for it. The board's action was reported to the association's House of Delegates.

New president of the organization is Lt. Col. Agnes P. Snyder, chief physical therapist in the Office of the Surgeon General, U. S. Army, Washington, D. C. She succeeds E. Jane Carlin, Jenkintown, Pa.

Abstracts of selected papers papers follow.

Ultrasound Irradiation

Ultrasound Therapy Safe for Use In Tissue Near Metal Implants

Ultrasound therapy can be safely used for irradiation of tissues adjacent to surgical metal implants, preliminary results of continuing studies indicate.

It appears that increased heat conductivity of the metal, relative to tissue, compensates for higher temperatures produced by the radiation.

Under some conditions there was actually a cooling effect in front of the metal implants. No destruction of tissue resulted.

Studies were made of tissues adjacent to various implants inserted into 100- to 150-pound pigs, which were irradiated postoperatively and later sacrificed.

No appreciable rise in tissue temperatures occurred as a result of exposure to the ultrasound. —*Justus F. Lehmann, M.D.*, professor and executive officer, department of physical medicine and rehabilitation, and *George Brunner*, director, division of physical therapy, University of Washington, Seattle.

Cerebral Palsy

Oversedation of Mother May Be Factor in Infant Cerebral Palsy

Oversedation of the mother near term may be a factor in the development of cerebral palsy in the infant.

In experiments on guinea pigs, we found that oversedation of the mother near term could produce young showing many of the neurological characteristics of the cerebral palsied child. Even mild sedation of the mother was not without its dangers for the newborn.

Eleven neurologic sequelae, none of which was found in the control animals, were encountered in the drugged infants during their recovery phase, including spastic limbs and inco-ordinate gait (57 percent), failure to walk (43 percent), atonia and cyanosis, delayed righting, head and trunk tremors, loss of startle reflex, and feeding problems.

All of the heavily anesthetized animals were apneic at birth and required positive-pressure resuscitation with oxygen to survive.

Seven of the lightly anesthetized animals (the control group) failed to breathe at birth, but only three required resuscitation. Of the lightly anesthetized group, 69 percent had delay in righting; 54 percent had head and trunk tremors; 46 percent, inco-ordinate gait, and 39 percent, spasticity. —*Eleanor Flanagan*, research assistant, and *R. Frederick, Ph.D.*, associate professor, department of anatomy, Duke University Medical Center, Durham, N. C.

Therapist looks over material at association's exhibit, showing services available from the national headquarters. Total membership in the APTA was 8,557 as of May 1—an increase of 559 over the total of 7,998 at the same time last year.

AMA Delegates Approve Campaign Against UMW, Other 'Closed' Plans

Shown at the inaugural ceremony for incoming president Gunnar Gundersen, M.D., are (l. to r.): E. Vincent Askey, M.D., Los Angeles, speaker of the House of Delegates; David B. Allman, M.D., Atlantic City, N.J., outgoing president, and Mrs. Allman.

• Immediate launching of a public-education campaign in opposition to the United Mine Workers' medical-care plan and other plans which deny participants freedom of choice of physician was approved by the House of Delegates of the American Medical Association at its 107th annual convention in San Francisco, June 24-27.

Delegates accused the UMW of a "rotten campaign of publicity," and said that every type of propaganda, "including lawsuits," was being waged against organized medicine.

Other resolutions approved:

—Called for congressional action to restrict hospitalization of veterans at VA hospitals to those with service-connected disabilities.

—Asked that a study be made to determine whether or not the growing practice by hospitals of encouraging staff members to conduct private office practice within or adjacent to the hospital is a major move toward the practice of medicine by hospitals.

—Emphasized that operating-room experience is valuable and necessary training for all nurses, and deplored the tendency to reduce the amount of such experience required in the curriculum for student nurses.

—Recommended that general hospitals, wherever feasible, be encouraged to permit the hospitalization of suitable psychiatric patients.

—A report on medical use of hypnosis, approved by the House, urged physicians and dentists to participate in high-level research on hypnosis, and condemned the use of hypnosis for entertainment.

The House did *not* adopt a resolution asking that the AMA establish a plan for accreditation of hospitals, limited to the problem of patient care, staff organization, and intern and resident training programs, and that the American Hospital Association limit its accreditation activities to the "strictly physical problems of hospital care."

In recommending that this resolution not be adopted, the reference committee on medical education and hospitals referred to a report of a special committee two years ago, which concluded that administrative and professional functions in accreditation could not be separated, and that accreditation should be done by the Joint Commission.

Louis M. Orr, M.D., Orlando, Fla., urologist, and vice-speaker of the House of Delegates, was named president-elect. He will succeed Gunnar Gundersen, M.D., LaCrosse, Wis., at the 1959 meeting.

Total attendance at the convention was 43,555, including 13,218 physicians.

Study on Staph.

Aseptic Technics, Good Housekeeping Bring Staph. Epidemic Under Control

An epidemic of staphylococcal infections at the Jefferson Davis Hospital, Houston, Tex., has been brought under control by stringent control measures, emphasizing the maintenance of aseptic technics and good housekeeping procedures.

During the epidemic, there were 324 recorded infections—123 in the newborn and premature nurseries, with 18 deaths. Of the remaining 201 hospital-acquired infections, 150 occurred in outpatients and 51 in inpatients.

A hospital committee on infections and antimicrobial therapy was formed, and it served as a fact-finding, co-ordinating, and advisory group to the various services involved. It is desirable to have the infections committee charged also with the responsibility of making recommendations regarding judicious use of antibiotics.

A subcommittee of the committee on infections and antimicrobial therapy should be established to

set up methods of reporting and recording infections. The committee should include a member of the surgical service, the laboratory service, nursing service, and services whose infection rate is unusually high.

A decision must be made as to what actually constitutes a reportable infection. Obviously, not all "positive cultures" represent significant infections.

An effort should be made to determine which infections are acquired after the patient's admission, and what factors contributed to their development.

At our hospital, it was felt that actual reporting could be best made by the nursing supervisor on each floor at a regular time each day. Assistance of physicians is needed in deciding which infections should be reported. The committee on records and the service representative should cross-check periodically on accuracy and completeness of these reports.

The committee on infections and antimicrobial therapy should meet at least monthly to review the infection rate and effectiveness of various control measures.

The single most important factor in control is good environmental hygiene. Certain changes in physical facilities, housekeeping procedures, and nursing technics were instituted. Serial air studies for bacterial counts in various locations and bacterial studies of fomites were of considerable aid in locating "danger spots."

During the height of the outbreak there was a daily meeting of representatives of housekeeping, nursing, and administrative staff, nursery service, obstetrical service, and the epidemiologic nurse assigned by the Communicable Disease Division of the Public Health Service.

One factor contributing to the success of infection control was sponsorship by the nursing department of a hospital improvement contest, purpose of which was to inspire individual pride in maintenance of high standards of work in personnel, both professional and nonprofessional.

Whenever possible, patients with antibiotic resistant staphylococcal infections should be managed as outpatients. It was found desirable to set up a special outpatient clinic, in an area physically separated from other clinics and with personnel not working in other areas in which highly susceptible patients were seen.

Infected hospitalized patients should be physically separated in isolation units with separate attending personnel. Degree and duration of isolation should depend on the amount of infected material exuding from the patient.

Because newborn infants are particularly susceptible to staphylococcal infections and may actually serve as a reservoir of infection within a hospital, it is especially important to control infections in this group. Nurseries which are physically separated and which have separate personnel should be established to include areas for: (1) uninfected infants of normal deliveries; (2) uninfected infants born of complicated deliveries; (3) infants suspected of having infections and infants born outside the hospital, and (4) infants having definite infections.

Ninety-seven percent of nosocomial strains at our hospital were resistant to penicillin; 52 percent were resistant to streptomycin, 78 percent to tetracycline, and 70 percent to erythromycin. Novobiocin, chloramphenicol, and oleandomycin have been used largely for limited indications, and most strains have remained sensitive to them.

Increased concern over indiscriminate use of antibiotics at Jefferson Davis Hospital led to a gradual decrease in antibiotic costs—from $13,103.61 to $5,819.51 per month over a five-month period—during the time the hospital's infections were high.—*Ellard M. Yow, M.D.*, professor of medicine, and *Martha D. Yow, M.D.*, both of Baylor University College of Medicine, Houston, Tex.

Radiation Hazard

X-ray Use Late in Pregnancy May Be Linked to Leukemia, Gene Mutations

Routine pelviencephalography is not recommended because of the possible hazard involved to the fetus and to future generations.

Studies now in progress seem to justify the suspicion that the incidence of leukemia or other

(Continued on next page)

Frank H. Krusen, M.D. (l.), professor of physical medicine and rehabilitation, Mayo Foundation, University of Minnesota, Minneapolis, received the AMA's 1958 distinguished service award from President Gunnar Gundersen, M.D., LaCrosse, Wis. Dr. Krusen is chairman of the AMA Council on Physical Medicine and a member of the board's special committee on rehabilitation.

Above: Robert Cohen, M.D. (l.), Kern General Hospital, Bakersfield, Calif., tells H. R. Mooi, M.D., Coldwater, Mich., about signal device for use of patient in an iron lung. An electronic system, attached to the lower lip of a patient, signals when he is in distress or in need of attention.

AMA continued

malignant disease in early childhood may be slightly increased by the diagnostic use of pelvic x-ray late in pregnancy.

Also, it is theoretically possible that this very mild radiation may produce mutations in the genes of mother or child, the effects of which may not be manifest for many generations.

Experience has shown that careful clinical study of the pelvis will suffice in 70 to 80 percent of obstetrical patients. Roentgenologic pelvimetry is of great aid in a doubtful case, but does not of itself determine the method of delivery to be employed. When it seems to be indicated, however, it should not be withheld, as the definite advantages more than offset the more or less theoretical disadvantages.—*Edward L. King, M.D., Isadore Dyer, M.D., John A. King, M.D.,* and *Milton J. Hoffman, M.D.,* department of obstetrics and gynecology, School of Medicine, Tulane University, New Orleans, La.

X-ray Exams

New Devices, Careful Technics Help Reduce Radiation Exposure

Exposure of reproductive organs to radiation during x-ray examinations can be reduced 75 to 85 percent by careful use of known methods and newly developed technical equipment.

Suggestions for achieving a lower radiation exposure include: Limit fluoroscopy to specific medical purposes, especially in children and infants, because fluoroscopic examinations yield the highest gonadal doses and make shielding of the reproductive organs more difficult; have a radiation physicist survey radiation equipment for radiation "leakage," out-of-date equipment, and adequacy of radiation barriers; place the x-ray tube the longest practical distance from the patient; be sure that the x-ray beam is limited to the part of the body under study; use new, fast x-ray film and high-speed intensifying screens, and develop films in newer chemicals with full-time temperature and control.

Among devices made and developed especially for children are lead rubber snap-on diapers and lead protectors for the reproductive organs and pelvic area.—*Wendell G. Scott, M.D.,* clinical professor of radiology, Washington University School of Medicine, St. Louis.

Below: W. G. Kubicek, M.D. (l.), University of Minnesota Medical School, Minneapolis, and Mrs. Jean Danz, occupational therapist, demonstrate use of the computer for oxygen-consumption rate in their scientific exhibit on cardiac and metabolic demands during rehabilitation procedures. Data illustrate metabolic and cardiac responses of young normal subjects during activities carried on during rehabilitation.

Hypnosis for Surgery

Open-Heart Surgery Performed On Patients Under Hypnosis

Open-heart surgery has been performed for the first time on patients under hypnosis.

One of the two patients operated upon "awoke" on command while her heart was temporarily bypassed.

The two patients—both teenagers—were hypnotized and then given small amounts of anesthesia.

The first of the two was a boy with a congenital infundibular stenosis of the heart. The most remarkable postoperative aspect of the case was the absence of complaint of pain. The boy remained placid, calm, relaxed, and co-operative through the postoperative course and was discharged on the 30th day in good condition.

Both children have returned to school and are getting along well.—*Milton J. Marmer, M.D.*, Beverly Hills, Calif.

Radar Alert

Radar Beam Exposure Produces No Ill Effects, Four-Year Study Finds

None of 335 individuals who have worked with or been exposed to radar beams have suffered any ill effects, a four-year study has shown.

Their exposure to radar varied from an occasional incidental contact with the beam to as much as four hours' exposure daily for periods up to four years. Some of them had regular exposure over 13 years.

The 335 employees were examined at intervals of six, 12, and 24 months in an effort to detect acute or cumulative biological effects of exposure. A similar nonexposed group was also examined.

No significant changes were found in the exposed group. Protective clothing was not worn by any of the individuals while in the radar beam, although precautions were taken to keep them from approaching too close to the beam.—*C. I. Barron, M.D.*, medical director, California division, Lockheed Aircraft Corp., Burbank.

New Approach

Calls for Study of Viruses As Cause of Human Cancer

The time has come to assume that viruses are responsible for most kinds of cancer and to design and execute research accordingly.

Acceptance of the hypothesis that viruses are etiological agents in cancer will stimulate new experimental approaches to the cancer problem.

Newer knowledge of certain properties of viruses and the recent advances in the test-tube cultivation of human cells warrant a marked change in our thinking on the problem of human cancer.

Since there is no experimental evidence that human cancer is infectious, many investigators believe that, because viruses are infectious agents, they cannot possibly be of etiological importance in human cancer. However, this is not a valid conclusion, because it is well known that animal tumor viruses may alternately be infectious and noninfectious, apparently because of variations in the amount of virus present.

Moreover, viruses may be so specific that a given virus will infect and cause disease only in one kind of cell in one kind of animal, and, hence, appear noninfectious under many conditions.

We know that viruses can persist in their hosts for generations, in either infectious or noninfectious form, that they can mutate to form new strains that cause different disease symptoms, and that viruses and genes are closely related. Viruses have been called "naked genes" and may ride as passengers in cells.

If cells have viruses as passengers and viruses can cause cancer, it is just as reasonable to assume that these diverse agents are affecting the virus as it is to assume that they are affecting the genetic apparatus of the cell.—*Wendell M. Stanley, Ph.D.*, professor of virology and biochemistry and director of the virus laboratory, University of California, Berkeley.

Quadriplegic Retraining

Teenagers Show Best Capacity for Rehabilitation after Spinal Injury

Teenagers who become paralyzed from spinal-cord injuries have a better potential capacity for rehabilitation than do adults.

Much younger quadriplegics are now entering hospitals than formerly. With the rising birth rate, increasing recreational pursuits, and the rising number of automobile accidents, spinal-cord injuries are expected to become more numerous.

Any potential for rehabilitation depends on the extent and site of injury in the spinal cord, the early treatment of the patient, and the patient's age. The very young lack insight and co-operate uncertainly. The adult and aged usually have ingrained psychological traits that are unpredictable. Teenagers, however, respond comparatively well to improving themselves when a rational program of rehabilitation is offered.—*Herbert Kent, M.D.*, University of Oklahoma Medical Center, Oklahoma City.

Pain Relief

Study Finds Anileridine Valuable Analgesic-Sedative in 500 Patients

Anileridine is a valuable addition to the present group of analgesic-sedative agents, we have concluded on the basis of a study of over 500 patients.

It is effective orally and parenterally and has a minimal amount of undesirable side-effects. It is

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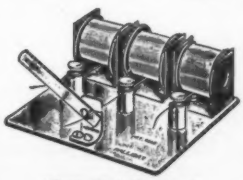
SAVE OPERATING ROOM TIME HELP THE SURGEON



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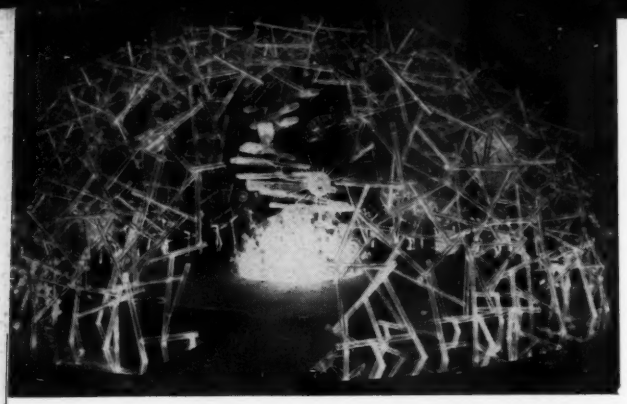

Giant, plastic model of a human cell was displayed by the Upjohn Co. More than 1,000,000 times as large as a red blood cell, the model—24 feet in diameter and 12 feet high—used a mile of plastic tubing and a mile of electric wiring, and took a year to plan and construct.

AMA continued

well tolerated by children as well as by patients of advanced age, and is effective in patients in both those age groups.

Further observations should be continued of the effects of anileridine in the management of patients with severely painful clinical conditions, such as ureteral colic, biliary colic, embolism, and coronary thrombosis, and patients with diabetes, asthma, and Parkinsonism.—*Robert C. Therien, M.D., Leroy W. Lee, M.D., Edward M. Malashock, M.D.,* and *Neal B. Davis, M.D.,* departments of anesthesiology and urology, Bishop Clarkson Memorial Hospital and the University of Nebraska College of Medicine, Omaha.

Scar Therapy

Fibrin-Foam Suspension Used To Treat Depressed Skin Scars

A group of 36 patients, with five varieties of depressed skin scars, were treated with fibrin-foam suspension over a three-and-one-half-year period.

Small, slightly depressed scars showed the least response to treatment. Undulating and "ice-pick" scars both showed marked and often spectacular improvement. Linear (traumatic) and "crater" scars showed slight to marked improvement, depending on the degree of atrophy of the epidermis, and loss of pilo-sebaceous orifices.—*Arthur S. Spangler, M.D.,* assistant in dermatology, Massachusetts General Hospital and Harvard Medical School, Boston.

Unresponsive Tumors

Lead-Rubber Grid Extends Range Of X-ray Treatment for Tumors

A lead-rubber grid has been used in an effort to extend the range of x-ray treatment to tumors hitherto adjudged irresponsive to irradiation.

The small apertures of the grid, by reducing the volume of tissue irradiated, greatly limit the quantity of secondary radiation. In 300 patients treated, no radiation sickness or blood changes were encountered, nor have any deleterious effects on bone been observed.—*Hirsch Marks, M.D.,* director, departments of radiotherapy and nuclear medicine, Harlem City Hospital, New York City.

Acne Study

Superficial Abrasion Therapy Helps Avoid Acne Scarring

Long-term continuous superficial abrasion has been used over a 10-year period in more than 1,000 patients with acne of all types. Used alone or with other treatments, this method often permits the young patients to outgrow the acne with little or no scarring.

The routine of abrasive washing seems in a large measure to replace self-manipulation of lesions.—*Rose B. Saperstein, M.D.,* Los Angeles.

Tetracycline Helpful in Controlling Pustular Element of Acne Vulgaris

Tetracycline controls the pustular element of acne vulgaris in the majority of cases, and substantially reduces scarring.

It may be given for several years without causing serious side-effects and without losing its beneficial effect. We found, as the study progressed among 485 patients, that the effective maintenance dose is lower than we originally thought. The exact mechanism of the beneficial effect is not completely understood.—*M. Allen Forbes, Jr., M.D.,* and *William C. King, M.D.,* department of dermatology and syphilology, University of Texas Medical Branch, Galveston.

Sneezing Cause

Investigate Allergy in Wheezy Child Before Removing Tonsils and Adenoids

The itchy, sneezy, wheezy child is usually allergic and should have thorough allergy treatment before removal of tonsils and adenoids is considered.

Allergic children often need their tonsils and adenoids out for the same reason (usually infection) as nonallergic children. However, a correct diagnosis of allergy will avoid or postpone surgery at least until the allergic problem is thoroughly treated.—*Norman W. Clein, M.D.,* Seattle, Wash.

"Therapeutics discussions," to give an opportunity to physicians to discuss their problems with specialists in antibiotics, biologicals, cardiovascular drugs, and tranquilizers, were held by Wyeth Laboratories at the company's exhibit at specified hours during the meeting. Here Joseph F. Fazekas, M.D. (l.), chief of staff, internal medicine, D.C. General Hospital, Washington, D.C., confers with George Farrar, M.D., medical director of Wyeth.

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(Patent applied for)

Now, for the first time, you can have emergency oxygen instantly available in completely equipped, hand-portable units located at every nurses' station. OXY-QUIK unit supplies a high concentration of oxygen for use while transporting patients and for emergency situations until routine oxygen therapy is set up.

Even if Your Hospital is piped throughout with oxygen, you need the *special emergency* help of OXY-QUIK. One lightweight unit — only 2½ lbs. — contains oxygen tanks, pressure reducing regulator,* mask and hose in a plastic carrying case which is designed to hang on walls; snap or clasp on stretchers, wheel chairs, beds and other hospital equipment. Units can be quickly gathered up and carried to disaster areas and first aid stations. OXY-QUIK is an entirely new and unique unit that requires no tools — wrenches or washers to operate. It's ON . . . it's OFF Tank is replaced in 30 seconds. Refills available anywhere in the world.

Even untrained help can use OXY-QUIK effectively! Full directions on every tank. It's ON . . . it's OFF ! Apply mask over mouth and nose to provide ample, steady flow (6 liters per minute).

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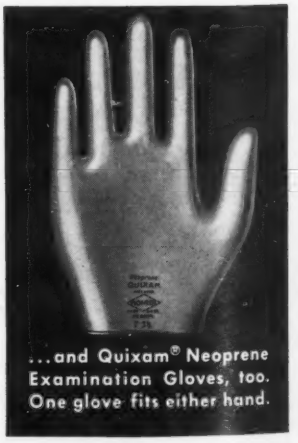
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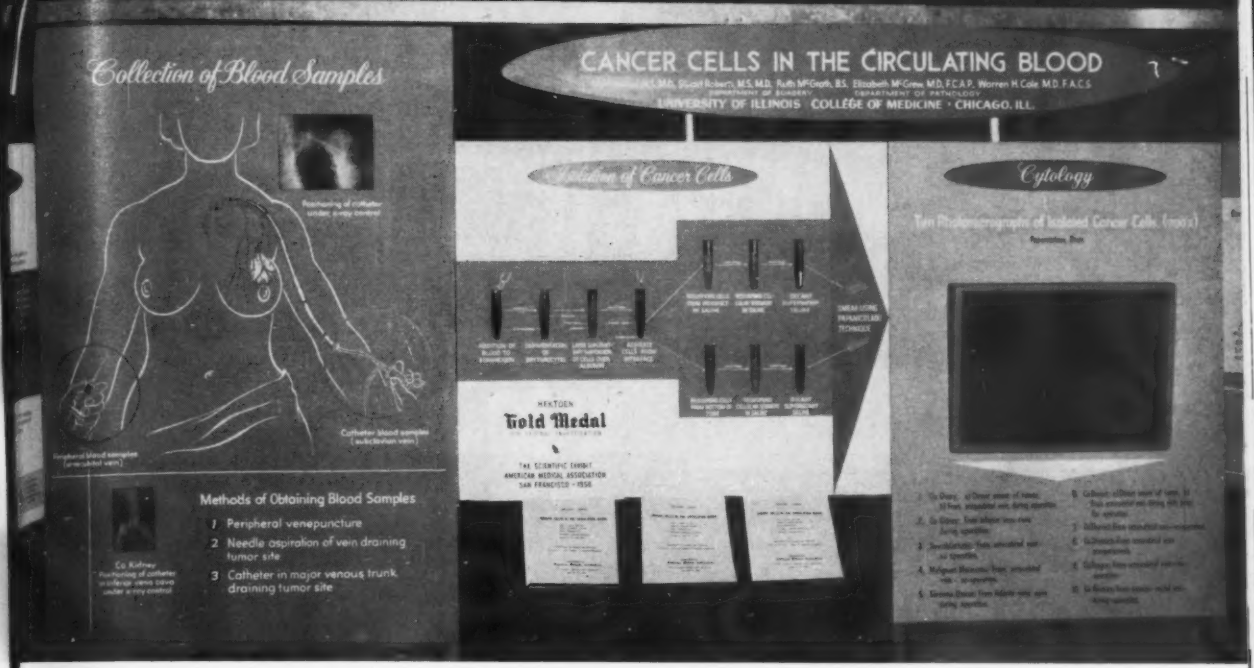
A TOPICS REPORT

AMA Scientific Exhibits


Collection of Blood Samples
Methods of Obtaining Blood Samples
1 Peripheral venepuncture
2 Needle aspiration of vein draining tumor site
3 Catheter in major venous trunk draining tumor site
CANCER CELLS IN THE CIRCULATING BLOOD
UNIVERSITY OF ILLINOIS · COLLEGE OF MEDICINE · CHICAGO, ILL.
Isolation of Cancer Cells
HEKTOEN
Gold Medal
THE SCIENTIFIC EXHIBIT
AMERICAN MEDICAL ASSOCIATION
SAN FRANCISCO · 1958
Cytology

AISLES in the scientific exhibit section at the annual convention of the American Medical Association in San Francisco were more crowded than ever this year with note-jotting physicians, endeavoring to learn as much as possible from their colleagues' reports on current research.

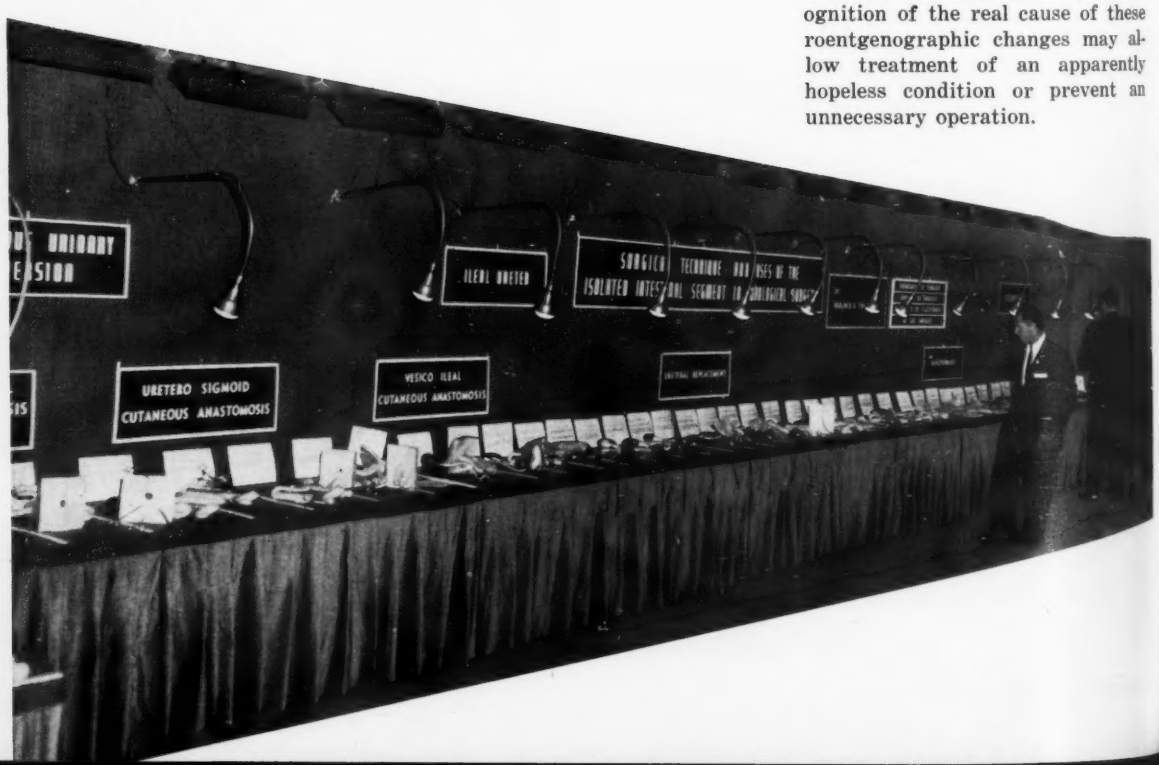
In this fifth annual pictorial report on the scientific exhibits, HOSPITAL TOPICS presents highlights from some of the many outstanding displays.

The Hektoen gold medal, for the best exhibit reporting on original investigation, went to the exhibit shown above—"Cancer Cells in the Circulating Blood" —by Alvin L. Watne, M.D., Stuart S. Roberts, M.D., Ruth G. McGrath, B.S., Elizabeth A. McGrew, M.D., and Warren R. Cole, M.D., University of Illinois College of Medicine, Chicago. Display illustrated mechanisms of venous spread of cancer and various methods of blood collection, and described technic for the isolation of cancer cells from the circulating blood.

L. to r.: Drs. Watne, Roberts, and McGrew accept award from Alphonse G. McMahon, M.D., St. Louis, chairman, Council on Scientific Assembly; Frank B. Queen, M.D., Portland, Ore., chairman, awards committee; and Thomas G. Hull, Ph.D., Chicago, secretary, Council on Scientific Assembly.

Billings gold medal, for excellence of presentation and correlation of facts, was awarded to exhibit on "Misleading Thoracic Roentgenograms," by C. H. Hodgson, M.D., J. A. Callahan, M.D., A. J. Bruwer, M.D., and A. H. Bulbulian, D.D.S., Mayo Clinic and Mayo Foundation, Rochester, Minn. Dr. McMahon (center) presents award to (l. to r.) Drs. Hodgson, Bruwer and Callahan. Dr. Queen is at right.

Exhibit pointed out that roentgenograms of the thorax in certain cardiovascular conditions may simulate those associated with diseases of the lungs, bony thorax, or mediastinum, and emphasized that recognition of the real cause of these roentgenographic changes may allow treatment of an apparently hopeless condition or prevent an unnecessary operation.



DISPLAY on surgical technic and uses of isolated intestinal segment in urological surgery (see picture at bottom of opposite page) won the Billings silver medal for Roderick D. Turner, M.D., University of California Medical Center, Los Angeles.

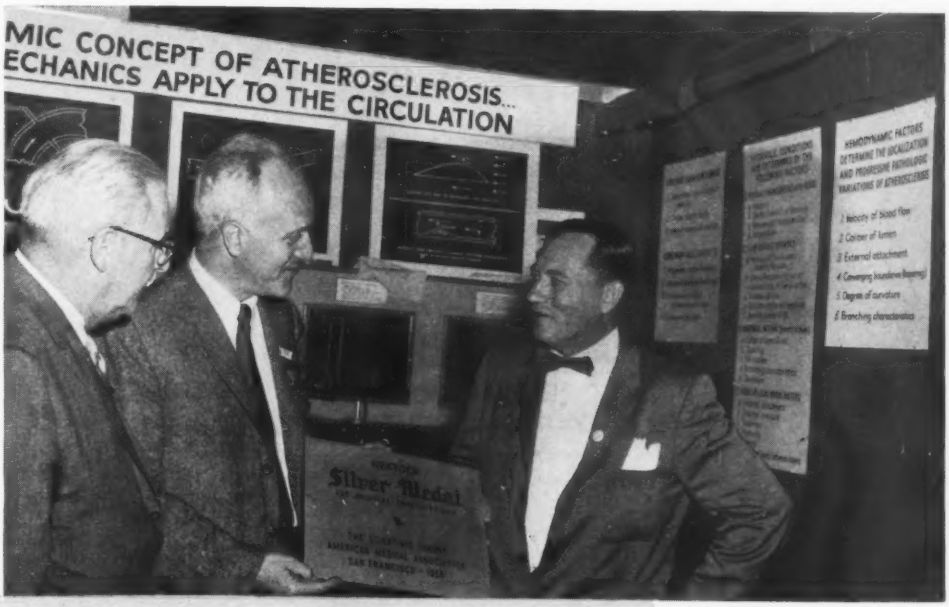
Exhibit showed surgical technic step by step, illustrating each suture placed in the Bricker (ureteroileal-cutaneous anastomosis) procedure, the ileal ureter, the ileocystoplasty, and the sigmoidocystoplasty, with their different surgical variations.

The isolated intestinal segment is used in cases in which physiological use of that portion of the urinary tract has been destroyed—perhaps by carcinoma, tuberculosis, x-ray therapy scar, or congenital anomalies.

WINNER of the Hektoen silver medal was the exhibit on the hemodynamic concept of atherosclerosis, by Meyer Texon, M.D., New York University Postgraduate Medical School and Office of the Chief Medical Examiner, New York City.

Dr. Texon(below, center) accepts award from Dr. McMahon (l.) and Dr. Queen.

Display, in which laws of fluid mechanics were applied to the circulatory system, presented the concept that the hemodynamic factor can account for the location of atherosclerosis and its progressive pathologic evolution, and that the composite effects of velocity of blood flow, caliber of lumen, degree of curvature, branching characteristics, and tapering determine the sites of predilection.

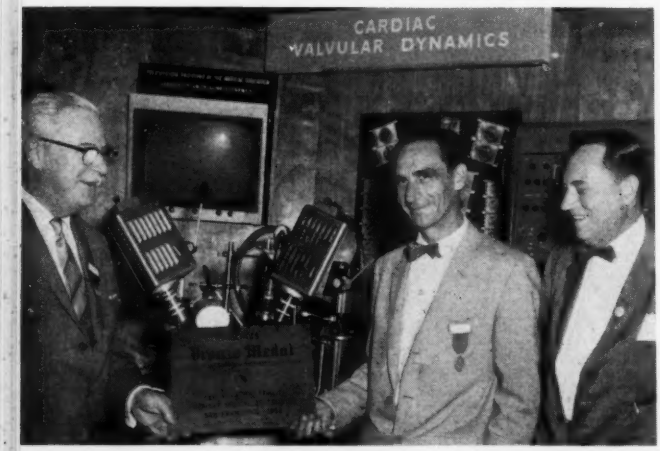


All photos by Hospital Topics

"CARDIAC Vascular Dynamics" won the Billings bronze medal for Julio C. Davila, M.D., Robert G. Trout, M.D., Joseph E. Sunner, and Robert P. Glover, M.D., from the Thoracic and Cardiovascular Research Laboratory, Presbyterian Hospital, Philadelphia.

Featured in display was the Presbyterian pulse duplicator, which makes possible the graphic study of both normal and diseased cardiac valves functioning under conditions which duplicate living cardiovascular dynamics. Instrument has proved useful in research on valvular mechanics, in the investigation of problems in circulatory dynamics simulated in vitro, and in research on development of advanced corrective operations applicable to valvular heart disease.

Daily demonstrations were conducted with fresh pathologic specimens.



At left: Mr. Sunner (center) receives Billings bronze medal from Drs. McMahon (l.) and Queen.

SUCCESS in a unique experiment utilizing a two-way radio network for conducting postgraduate instruction was reported in exhibit by Frank M. Woolsey, Jr., and William P. Nelson III, Albany (N.Y.) Medical College.

Twenty-one hospitals throughout eastern New York and western Massachusetts participate in the conferences, which are held 24 weeks a year, November through April. The program has been in progress for three years.

Basic facilities involved in the network consist of a high-powered transmitter located on a mountain near the college, and transmitters of lesser power in each of the 21 hospitals. The hospitals have receivers so that they can hear the faculty, and the college has a receiver so that it can hear the participating physicians gathered at each hospital.

The first half of the one-hour program is presented by three or four faculty members, one of whom acts as conference moderator. During the second half-hour the participating hospitals transmit their questions via the physicians designated as local moderators. Everyone hears the questions and the answers, which are given immediately.

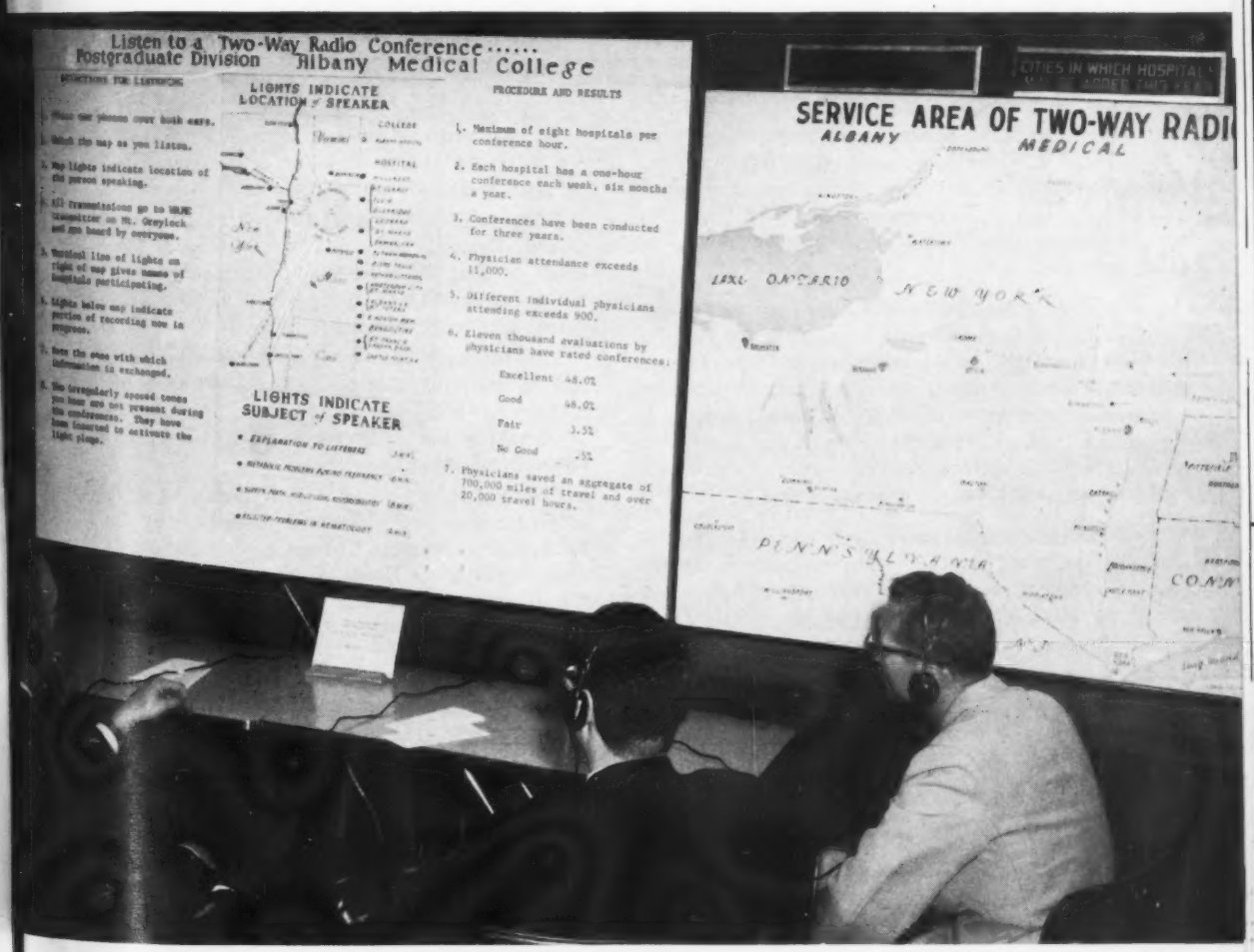
Only eight hospitals are included on a given day, since bringing in more than that number would make it impossible to answer all questions. Therefore, the same conference is presented on three different days.

Attendance at these conferences has enabled the faculty, with less effort, to bring pertinent postgraduate information to five times as many individual physicians as have been attracted to the school's intramural postgraduate presentations during the same period (the last three years).

The American Academy of General Practice approves the conference for postgraduate credit.

Inclusion of hospitals in Vermont, Rhode Island, and Connecticut is now under consideration.

Below (l. to r.): Robertson Ward, M.D., San Francisco; William Gittinger, M.D., New York City; Harry Wiener, M.D., Pfizer Laboratories, Brooklyn, N. Y., and William P. Nelson III, M.D., Albany.


Listen to a Two-Way Radio Conference.....
Postgraduate Division Albany Medical College
LIGHTS INDICATE LOCATION of SPEAKER
LIGHTS INDICATE SUBJECT of SPEAKER
PROCEDURE AND RESULTS
1. Maximum of eight hospitals per conference hour.
2. Each hospital has a one-hour conference each week, six months a year.
3. Conferences have been conducted for three years.
4. Physician attendance exceeds 11,000.
5. Different individual physicians attending exceeds 900.
6. Eleven thousand evaluations by physicians have rated conferences:
Excellent 48.0%
Good 48.0%
Fair 3.5%
No Good .5%
7. Physicians saved an aggregate of 700,000 miles of travel and over 20,000 travel hours.
SERVICE AREA OF TWO-WAY RADI
ALBANY MEDICAL
ONTARIO
NEW YORK
PENNSYLVANIA

WINNER of Hektoen bronze medal was exhibit entitled, "Chemopallidectomy for Dystonia and Other Juvenile Involuntary Movement Disorders" (above), by Irving S. Cooper, M.D., New York University-Bellevue Medical Center and St. Barnabas Hospital, New York City.

Results were reported with the use of chemopallidectomy or thalamectomy, or both, in 50 cases of diverse extrapyramidal disorders in children. Investigation has demonstrated, exhibitors say, that the involuntary movements of dystonia musculorum deformans, as well as those of choreo-athetosis, are completely reversible by these technics, without necessarily inflicting any additional neurologic deficit.

Most striking results have been complete reversal and alleviation of dystonia musculorum deformans, even in advanced stages. Not only involuntary movements but also fixed postures and deformities have been reversed.

• Promising results have been obtained in preliminary trials of a new oral drug for diabetes, according to an exhibit by Leo P. Krall, M.D., Boston, and a group of physicians. The drug is formamidinyliminourea, called DBI. It is unrelated to the sulfonylurea tolbutamide.

Exhibit reported on results with a total of 199 patients treated for periods up to 18 months, in three separate series from different institutions.

Of the 173 patients treated with DBI at the Joslin Clinic, Boston, 107 showed a lowered blood-sugar level; 43 had the level lowered but could not tolerate the drug, and 23 failed to be helped. Thus, about two-thirds of the group responded.

Patients were unselected as to severity, duration, or age at onset of diabetes. About 30 percent of Dr. Krall's patients were juveniles, some of whom had been taking the drug for a year, along with small amounts of insulin.

• Use of a small aerosol unit to aid in early detection of lung cancer was described in exhibit by Gustav J. Beck, M.D., Columbia University College of Physicians and Presbyterian Hospital, New York City. Nebulizer for diagnostic use has built-in heater thermostat which warms a salt-spray solution to a maintained temperature of 125° F. Heated solution is sprayed into the bronchi, causing patient to cough up secretions which can be examined for cancer cells.

Method is said to be effective in detecting lung cancer when diagnosis is not suspected or is in doubt because of inadequate x-ray evidence or the patient's inability to raise sputum spontaneously.

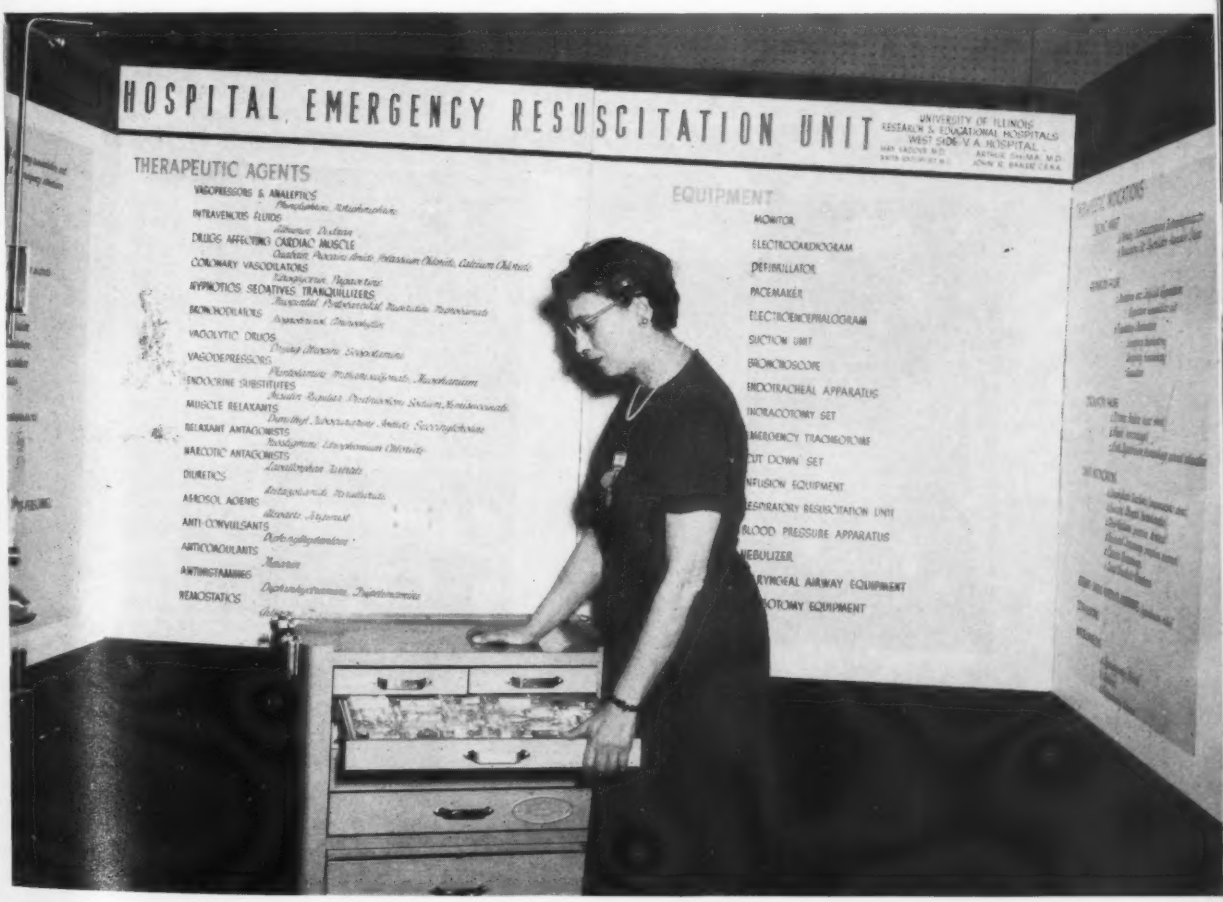
A HOSPITAL emergency resuscitation unit was exhibited by Max S. Sadove, M.D., Anita E. Rapoport, M.D. (shown below with cart), and Arthur T. Shima, M.D., anesthesiology department, University of Illinois Research and Educational Hospitals, Chicago, and John P. Baker, C.R.N.A., West Side VA Hospital, Chicago.

The cart is invaluable, according to the exhibitors, in cardiac, circulatory, respiratory, and aspiration resuscitation, and in the treatment of poisoning and convulsions.

It has a fixed station when not in use. When the location of an emergency is designated, an appropriate signal causes the unit to be brought from its control station.

Trained personnel selected from the medical and nursing staff must be available around the clock for the utilization of this unit, the exhibitors emphasized. The user of the unit must be responsible for its immediate return to the control point. Supplies must not be used for non-emergency treatments.

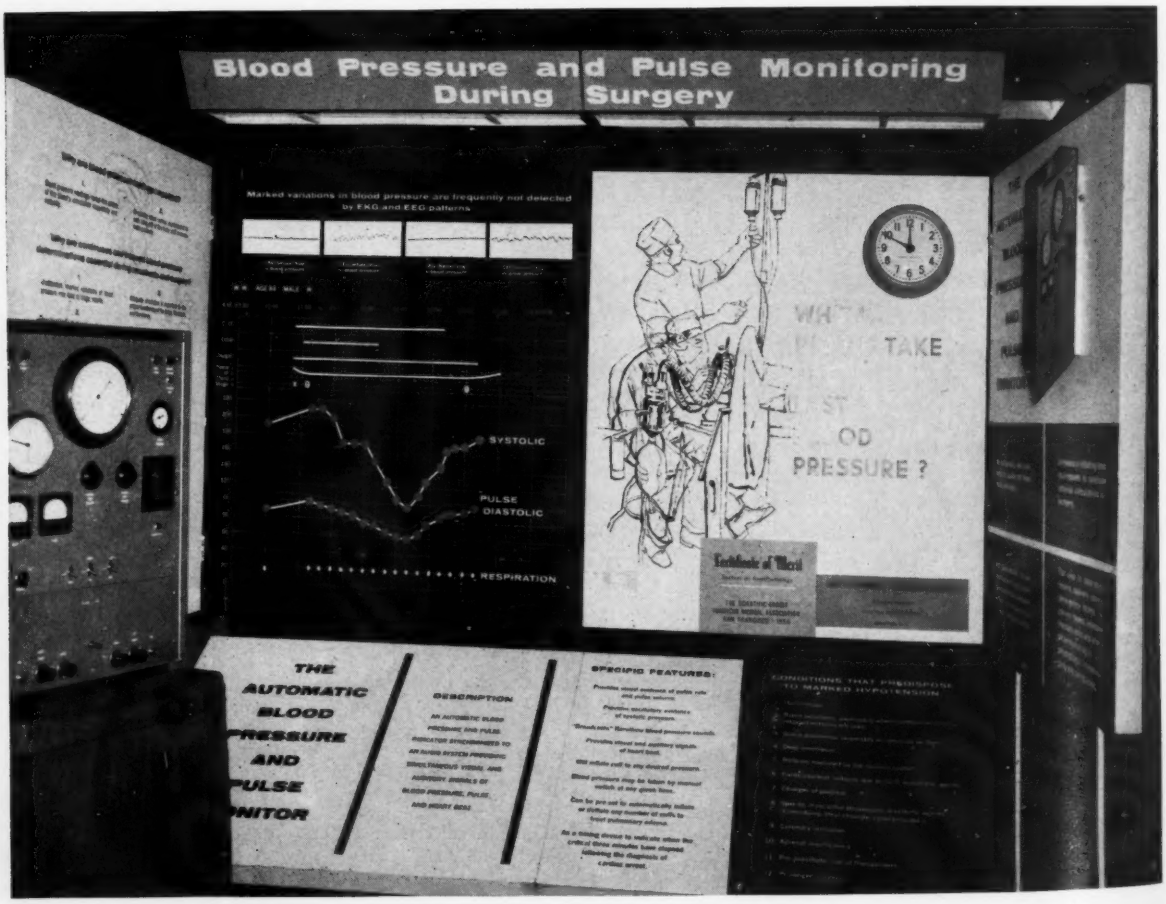
They also pointed out that a cart of this sort should have enough space to permit arrangement of supplies for instant detection by the eye; that the outside of the cart should have a source of oxygen; that electrical diagnostic and therapeutic equipment should be placed five feet above the floor, and that lead wires should be connected to their respective instruments, so that time will not be lost in haste to make the right connections.



Examinations for Rh factor were featured at exhibit by Ervin E. Nichols, M.D., and A. Warren Olson, M.D., College of Medical Evangelists, Los Angeles. Display included information on hemorrhage, titer significance, homozygous or heterozygous factor of the father, indications for termination of pregnancy, and prognosis for the baby.

CERTIFICATE of merit in the anesthesiology section went to exhibit on continuous monitoring of circulation during surgery, by Dante Bizzarri, M.D., and Joseph Giuffrida, M.D., Columbus and Elmhurst General Hospitals, and New York Medical College, New York City.

Display included an automatic blood-pressure, pulse, and heart sound monitor which provides visual evidence of pulse rate and volume, oscillatory evidence of systolic blood pressure, and visual and auditory signals of the heart beat; broadcasts Korotkow blood-pressure sounds; will inflate blood-pressure cuff to any desired pressure; automatically determines blood pressure at any given instant, or repeatedly at pre-set intervals, and can be used as a timing device to indicate when the critical three minutes have elapsed following the diagnosis of cardiac arrest.



Administration—Off Hours

By John E. Vanderklish*

• Various organizational systems have been devised by hospitals to insure effective supervision for evenings, nights, weekends, and holidays. Malden Hospital employs a system based on unity of command: One individual, called a supervisor, is charged with full responsibility and invested with all authority. We trust that this unity will produce supervision as just as it is powerful.

In purely administrative matters, this supervisor-in-charge is responsible solely to the director of the hospital; in matters which affect nursing care, she is responsible to the director of nurses.

To carry out her dual responsibility, she commands the full authority of the director in executing hospital policy, supervising personnel, and directing the activities of resident physicians in administrative matters, and the full authority of the director of nurses in maintaining good nursing care according to the standards of the nursing service department.

Two prime requisites to the successful operation of this system are the maintenance of up-to-date written policies and well-regulated written and oral reports. Good rules make it easier to do right and harder to do wrong.

Written policies and procedures clearly delineate for the supervisor the exact limitations of her responsibilities and her authority. Her responsibilities can be telescoped into one statement: *She must make certain that all hospital policies are carried out.* Her authority should be expanded so that although she may exercise judgment in enforcing policies, she may not act, except in an unforeseen emergency, in areas not covered by policy; nor may she give an order contrary to any existing policy; nor may she devise new policies. The supervisor's authority can thus be described as executive, and not legislative.

Great pains have been taken to reduce each policy to writing and to relegate it to the proper policy manual. These manuals constitute the very backbone of off-hour administration.

All policies affecting the hospital itself have been incorporated into a "Hospital Policy Manual." The first two pages of the manual describe its scope, provide for the automatic incorporation of all new directives, and set up a permanent hospital policy committee. A distribution list has been prepared showing the exact location of all 30 copies—director's office, assistant director's office, nursing school office, all departments, all wards, nursing service office, and doctor's lounge, and exactly which manuals each committee member is responsible for keeping up to date.

Specific policies governing resident physicians and resident medical students are contained in a manual of regulations entitled: "Administrative Regulations for the Resident Staff." This completely indexed brochure is brought up to date every year and a copy presented to each new resident. One of the first pages constitutes an agreement to abide by the regulations set forth. It is signed by each resident and retained in the director's office. A copy of the manual is available to the off-hours supervisor.

Policies governing the medical staff are, of course, found in the "By-Laws of the Medical Staff" and in the "Rules and Regulations of the Medical Board for the Medical Staff." Copies of both are provided for each supervisor. We are perhaps fortunate in that all policies, by-laws, and rules and regulations have been woven into a unified whole. In this way, each complements the other, and contradictions are avoided.

The detailed procedures followed in various departments of the hospital are found in specifc departmental procedure manuals such as the "Credit Office Procedure Manual" and the "Admitting Office Procedure Manual." These "dictionaries on detail" are available to supervisors any time a question arises as to procedure.

The limits of the supervisor's responsibility and authority in emergencies such as fire, power failure, and disaster are clearly set forth in documents such as the "Hospital Fire Plan" and the "Hospital Disaster Plan-B Major." Without such definite written policies and procedures, the delegation of authority to supervisors on off-shifts would be without control.

Even though we have all of these manuals, we treat them with moderation. We merely believe that the more extensive is the knowledge of the supervisor of what has been established as a procedure, the greater will be her ability in knowing what to do.

The second prime requisite for the successful operation of this type of off-shift administration is a report procedure. When the administrator or the director of nurses delegates authority to an off-hour-shift supervisor, neither is relieved of final responsi-

(Continued on next page)

*Director, Malden (Mass.) Hospital.

bility. The ceaseless aspect of their responsibility necessitates a constant flow of information from the supervisor.

Our communication procedure requires a written daily report to the director of noteworthy administrative happenings, and a written daily report to the director of nurses of noteworthy happenings pertaining to nursing.

Our off-hour-shift supervisors approach problems in specific areas, such as admitting and pharmacy, from this vantage point.

ADMITTING OFFICE

True admitting problems within an operative system such as the one described dwindle down to three.

(1) Coverage. A delicate balance must be struck so that the supervisor-in-charge does not become overburdened with detail and so that, on the other hand, man hours are not wasted. Admitting officers are assigned from 7 a.m. to 11 p.m., seven days a week. It has been found in repeated studies that the number of admissions after 11 p.m. at the Malden Hospital neither warrants the presence of a full-time admitting officer nor overtaxes the supervisor's time.

Each supervisor is thoroughly oriented in the admitting office and with the admitting procedure book. If for some reason she does not have time to carry out all steps, she knows which ones may be deferred until the regular staff arrives at 7 a.m.

(2) The emergency patient requiring admission, but who because of his condition cannot be controlled—an example is the injured inebriate who should be admitted for observation—who is visibly disturbed. The supervisor must decide, in conjunction with the physician, whether or not the case is amenable to nursing care in one of the specially barred and soundproofed rooms for disoriented patients, or whether the patient must be immediately transferred to an institution especially equipped to handle his type of case.

If it is decided to admit the patient, she must follow through with close supervision and a written report to the director of nurses. If it is decided that the patient must be transferred, she may consult the "Special Services Department Procedure" book for the proper institution to be contacted and the proper manner of affecting the transfer, and she must submit a short written report supporting her decision.

(3) Finances. Each supervisor can read in the manual that a pre-admission deposit of $50 must be requested of a patient covered by Blue Cross. She knows that if a patient does not bring $50 he must be referred to the credit manager. But in the off-hours the credit office is closed and almost all admissions are emergencies. Another hospital policy states that emergency cases will be admitted despite financial considerations.

The solution to the problem (and the only way of preventing the loss of many dollars to the hospital) lies in instituting proper credit forms and building up the supervisors insight into the hospital's credit problem. If the supervisor completes the admitting contract and the master admitting form, the credit manager will have at his disposal the following business day a complete list of all insurances covering the patient, the name of the financially responsible person, and a signed promise to pay all bills and charges.

If she has gained the insight we have tried to instill into her during our orientation period, she will also make a marginal note—in the space allotted—a brief assay of the situation with valuable leads to the patient's true financial status.

PHARMACY

The chief administrative problem posed by the pharmacy during off-hours again is coverage.

Since few hospitals are staffed by a registered pharmacist at night, provision must be made for dispensing emergency medications. This responsibility is often reserved for the night supervisor, since she is best qualified to handle it. The problem becomes one of setting up the emergency service so that it consumes as little time as possible.

The following steps are taken to accomplish this:

A large number of common medications are stocked on the floors. These include not only such items as Empirin and digitalis, but also narcotics, which are kept under double lock at all times.

A registered pharmacist is on duty from 7 a.m. to 6 p.m., seven days a week. If a medication not on floor stock is requested after 6 p.m., a special red emergency requisition slip must be filled out and signed personally by the physician. Each emergency slip has a stub on which is recorded the date and the time of the request. At the end of the month, the stubs are analyzed for excessive emergency requests and are used for statistical purposes.

The arrangement of medication in the pharmacy has an important bearing on the amount of time spent by the supervisor in dispensing medications and incidentally on the efficiency with which she meets hospital needs. At Malden Hospital, all drugs are segregated according to form. Liquids, powders, and tablets, for instance, are all separated; the individual drugs in each category are then shelved alphabetically and clearly marked so that it would be a simple matter even for a new supervisor to find emergency drugs.

The pharmacy problem which harasses administrators more than any other is that of safety. The problem becomes more acute during off-hours, in the absence of a registered pharmacist, and requires special attention during such periods.

The following precautions are observed. All medications to be taken internally are stored in areas completely separate from external medications, and all internal medications that are fatal if taken in large doses are labeled "POISON." The " emergency" cabinet in the pharmacy, containing such items as Demerol, papaverine, ACTH, and cortisone, is kept locked. The supervisor retains custody of the key to

this cabinet and may dispense drugs, with just one limitation—she may not mix or compound drugs.

If a physician orders a medication which requires compounding, the supervisor calls the physician and explains the situation. If he still requires the drug, she telephones the hospital pharmacist on call or obtains the item from the local pharmacy. The same procedure is followed when a physician requests a medication which is not stocked. A current file index of all items stocked in the pharmacy and a set of up-to-date reference books are kept on hand. Any doubt as to the use of the drug can be readily absolved.

The problem of pricing drugs during off-hours is eliminated by having this done by the pharmacist the following day. The supervisor need only enter on the charge slip, the patient's name and room number and the type and quantity of the drug.

LABORATORY AND X-RAY

All coverage problems in the x-ray and pathology departments should be obviated for off-hour-shift supervisors by the establishment of 24-hour service, at least on an on-call basis.

Many methods or combinations of methods may be employed. Our laboratory is covered from 5 p.m. to 8 a.m. by a panel of approximately 10 on-call technicians, most of whom do not hold daytime positions in the department, and all of whom are compensated on an hourly basis for the time they spend on call, whether or not they work.

The x-ray department utilizes a combination of methods to assure coverage without overtaxing the regular staff. On three nights a week, the department is covered from 4:30 p.m. to 8 a.m. by a male technician who receives a weekly stipend whether he is called or not. Saturday afternoon, Sunday, and the other evenings are covered by the regular technicians, who receive a stipulated amount for remaining on call, plus their regular hourly rate for the time worked.

The blood bank, which is staffed by registered nurses only, and supervised by the pathologist, cannot be so covered because of a personnel shortage. Blood-bank nurses are present from 8 a.m. to 4:30 p.m. four days a week and to 8 p.m. three days a week. During off-hours the responsibility of securing blood rests with the supervisor. It is most important that she understand every detail of the proper procedure.

MEDICAL AND SURGICAL SUPPLIES

The problem of supplies during the off hours can be summed up as that of providing ready access to emergency supplies, and of preserving stringent control without squandering the time of personnel or of the supervisor.

The most important step in accomplishing this consists of providing 24-hour coverage in the central medical supply department. This can be done most economically by spreading out the work load over a 24-hour period so that fewer personnel are required on the day shift and so that the off-hour personnel can be usefully occupied.

Round-the-clock central medical supply service, incidentally, eliminates a number of other difficulties such as (1) over-ordering by nursing units, in preparation for an emergency, before the department closes; (2) lack of equipment needed for a dangerous surgical operation; (3) slowing down of early morning work while trays used during the night are sterilized and replenished before the day's work begins.

For securing emergency supplies not stored in the central medical supply department, the off-hours supervisor should be able to gain access to all stores. This is accomplished through the use of a master key control panel. Each key in the control cabinet is kept on a separate hook. Both hook and key are coded against a master-list. Any supervisor removing a key replaces it with a signed slip indicating when she removed it. In this way the supervisor always finds either the key or an indication as to its location.

RELATIONS WITH POLICE

The police department solves many more problems for the off-hours supervisor than it creates. It provides ambulance service to and from the hospital. Police notify the supervisor in advance when an unusual case is on the way or if more than one person is being brought at the same time. To avoid moving a patient more than necessary, police will remain with the patient until a preliminary examination has been conducted. They are happy to convey him to the x-ray department, or even to his room.

(Continued on next page)

HOSPITAL TRENDS
By Louis Block, Dr. P.H.

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The police requirements are few. A complete listing of cases reportable to the police has been incorporated in the hospital policy manual. These include cases showing evidence of violence, automobile accidents, and drownings, to name a few. Supervisors are instructed to answer all possible questions regarding these cases and to provide an opportunity for officers to question others familiar with them. If the case is unusual—for instance, if it involves a well-known personage—standing orders are to contact the director of the hospital at once.

PRESS RELATIONS

Problems involving the press are handled much the same way at Malden Hospital. The hospital policy manual following the Massachusetts Hospital Association's bulletin entitled "Hospital-Press-Radio-TV Co-operation," spells out exactly what information may routinely be released to reporters and what information should not be released.

Supervisors are instructed that on all routine matters they are the official hospital spokesmen. This distinction between a routine matter and a non-routine matter naturally must be left up to the discretion of the off-hour-shift supervisor. Decisions in this area constitute the most difficult ones she may be called upon to make. I consider it vitally important to impress upon the supervisor that when the seriousness of a public-relations problem is in question, and she is in doubt, she should call the director.

Certain public-relations problems must be handled right the first time; there is no second chance. Sometimes this involves getting the hospital's story to the press first. Newspapers in the last year or two have been filled with news on the type of problem I have in mind: suicides and attempted suicides at night; patients who go out the accident-room door shouting to the world that they were refused emergency service, and the hospitalized prominent person.

POWER FAILURE AND FIRE

Disaster emergencies, such as fire and power failure, cease in some degree to be emergencies or problems if they are thoroughly prepared for. No effort must be spared in setting up procedures designed to cope with emergencies and to acquaint supervisors with them.

We have taken the following precautions against the possibility of power failure:

(1) The hospital's 1,600 ampere electrical distribution has been set up to provide a dual service—one for normal and one for emergency use. A switch automatically transfers the hospital onto the emergency service if the normal service fails or if the voltage on the normal service drops below 70 percent of capacity. When full voltage has been restored on all phases of the normal source, the load will automatically transfer from the emergency to the normal source.

(2) Ideally, the next logical precaution would be the installation of a generator with sufficient kilowatt capacity to sustain complete electrical service and with an automatic cut-in. We do not as yet have such a generator, but negotiations for one are now being carried on.

(3) A hospital without its own source of power must carefully work out a detailed procedure to cover power failure. Our written procedure requires the supervisor to notify first the director of the hospital, then the director of nurses. Next she has the switchboard operator call key personnel, such as the chief engineer, in the order named on the emergency list. Then she is to arrange for the hospital's four 2,500-watt generators to be used in the vital areas of the hospital.

The final section of the procedure lists the names and telephone numbers of other sources of help which may be needed—for example, the name and phone number of the local director of civil defense, who is on 24-hour call, and who has four more emergency generators at his disposal; the name and telephone number of the hospital's source of dry ice. The local civil defense station is five minutes away and is manned 24 hours a day by over 100 men volunteers.

The hospital's fire planning, of course, involves more detail. A written and periodically revised fire plan is posted in every department and at each nursing station. This plan is exercised every month—drills being scheduled for different hours of the day.

The plan calls for notification of the director immediately after the alarm has been turned in, no matter when the fire breaks out and no matter how small it seems to be. When a fire breaks out during off-hours, the supervisor is in complete charge until the fire department and the director arrive.

Disaster planning calls for even more detail. Besides posting a copy of the disaster plan in each department and at each nursing station, it has been found necessary to prepare six copies of a key disaster manual—for the director's office, the assistant director's office, the accident room, the chairman of the medical staff disaster committee, the admitting office, and the nursing-service office.

If a disaster should occur in the off-hours, the supervisor in charge would have, in this manual, ready access to an indexed copy of the hospital disaster plan, the community disaster plan, the medical staff disaster assignment list, all telephone call lists, and all forms used by the hospital during a disaster. These forms include admitting office room lists, nursing-service office personnel assignment lists, and lists of volunteers, and a set of the switchboard operator's condensed instructions.

From part 1 of the hospital disaster plan, which appears on page one of the key manual, the nursing supervisor can read the conditions under which the plan is to be used, and her authority if a disaster should occur in the off-hours:

> **"Only the hospital director, or, if he cannot be easily reached, the person next in charge, will issue the order to put plan B into effect. The plan is to be put into effect by notifying the switchboard operator."**

The World and Medical Care—Part IV:

Medical Care In Great Britain

By John G. Steinle

EDITOR'S NOTE: This article, the fourth in a series on medical care abroad, includes a discussion of hospitals in Great Britain and the National Health Service, and answers by the Ministry of Health to specific questions asked by Mr. Steinle regarding the operation of the National Health Service.

• The hospitals in Great Britain are generally old. There are very few private and semiprivate rooms. The operations of the hospitals are adequate, according to American standards. While most of the larger hospitals do not have all of the equipment and mechanical devices of the American hospitals, many have one or two outstanding departments. Certain departments, such as x-ray therapy, appear, on the average, to be superior to their American counterparts.

The laboratory tests appear to be more extensive, less routine, and often more involved than in American hospitals. For example, specimens containing staphylococci and streptococci are commonly cultured to determine their resistance to antibiotics.

Routine nursing, unlike that in any other country in Europe, is on a par with that in the United States. The nurses (called sisters) are well trained and hard-working. As in the United States, there is a great deal of experimentation and research on nursing education.

The National Health Service Act of 1946 transferred almost all the hospitals and clinics (2,835 and 585 respectively), together with their staffs of more than 320,000 full-time and 70,000 part-time workers, to the control of the Ministry of Health.

Most patients are accommodated in general wards, but single rooms or small wards are available without charge for those needing them for medical reasons. In addition, many hospitals have some "amenity beds" in single rooms or small wards. Patients who desire privacy which is not considered necessary for medical reasons may be accommodated in these beds for a charge of six or 12 shillings ($.84 or $1.68) a day, depending on the size of the room. In other respects such patients are treated in the same way as patients in general wards, and no charge is made for treatment or normal maintenance.

At some hospitals a number of "pay beds" are set aside for the use of patients who prefer to make private arrangements to be treated by a consultant of their own choice outside the service. A patient using one of these beds is required to pay the full cost of maintaining it and the fees of the consultant treating him. In most instances there is a maximum limit to the fees that a consultant may charge to patients occupying private-pay beds.

Convalescent treatment is provided for patients recovering from illness who require regular medical supervision and nursing care as well as rest, good food, fresh air, and regular hours. Facilities, however, are still rather limited.

All inpatient treatment is free of charge unless a patient chooses to have an "amenity bed" or a more expensive appliance than is considered clinically necessary, or to be treated as a private patient.

Outpatient treatments are free, except that outpatients are required to pay a charge of one shilling ($.14) for each item on a prescription form.

After the National Health Service Act was passed in 1946, the country was divided into 14 large hospital regions. Each region has at least one medical school and affiliated teaching hospital. Regional boards are responsible for local administration.

Except for the teaching hospitals in their areas—with which they naturally work closely—these regional hospital boards have been made responsible, under the general guidance of the Ministry of Health, for planning and co-ordinating the development of the hospital and specialist services of their regions and for the general supervision of their administration, particularly in relation to expenditures.

Their duties generally include being responsible for any capital works at hospitals in the region, for appointing hospital management committees, for allocating maintenance monies and approving estimates of expenditures, for appointing consultants and other senior medical and dental staff, for running the blood-transfusion and mass-radiography services of the region, and for making contractual arrangements with hospitals outside the service.

The day-to-day administration of the hospitals is entrusted to hospital management committees appointed by and responsible to the boards. At present there are 388 management committees of various sizes and patterns.

Generally, a committee administers a group of hospitals capable of meeting the ordinary needs of a district, such as a town and the country areas around it, or a group of neighboring towns with the country in between. Some committees, however, are respon-

(Continued on next page)

sible for a single hospital (usually a large mental hospital or hospital for the mentally deficient), and others for a group of hospitals of one kind (such as sanatoria).

TEACHING HOSPITALS

The administration of teaching hospitals is entrusted to 36 boards of governors, 26 in London and 10 in the provinces, who combine the functions of a regional board and a management committee, in that they are responsible for the administration of a group of hospitals for which they are directly answerable to the Minister of Health.

Patients are usually referred to hospitals by their "general physician." Each year, each person or family may select its physician who provides general services. These physicians refer patients to hospitals when hospitalization is required. Patients may also be referred to outpatient clinics or may go of their own accord.

The waiting list for hospitalization on December 31, 1957, was 431,000, about 13 percent of the annual number of discharges. The average waiting time varies by service and location. In the London teaching hospitals the waiting period for general medicine is 14 days, while for traumatic and orthopedic surgery and for ear, nose, and throat surgery it is 87 days. In provincial teaching hospitals the waiting period is from 13 days for general medicine to 133 for ear, nose, and throat surgery. The average waiting period for gynecological surgery is 88 days in London and 126 days in the provinces.

One reason for the long waiting lists is the long average day stay of patients, which is much longer in Great Britain than in the United States. The following table demonstrates the average length of stay for specific services by types of hospitals:

Average Length of Stay by Specific Service Great Britain—1957

	Non-Teaching Hospitals	London Teaching Hospitals	Provincial Teaching Hospitals
General medicine	22.2	23.0	18.9
General surgery	13.5	15.4	12.4
Traumatic and orthopedic surgery	26.4	26.6	18.1
Ear, nose, and throat surgery	5.6	7.7	6.7
Gynecology	10.7	12.3	11.1
Obstetrics	11.7	12.5	11.4

Another reason for the long waiting period to enter a hospital is the insufficient number of beds. During the depression period, 1929 to 1937, and during the war period, 1937 to 1946, no new hospitals were built. Very little was spent during these periods on remodeling and refurbishing. Since 1946 the number of beds has increased only seven percent.

The annual capital expenditures are only five percent of the total annual operating expenses. The highest annual capital expenditure since the inception of the National Health Service Act was in 1957, when 13,188,000 pounds was spent. This is equivalent to approximately $37 million, about one-sixth the total annual amount authorized by the Hill-Burton Act.

A general physician receives the major part of his income from a capitation fee. This is based on the number of patients who have selected him as "their doctor" for the year. The patients who have selected a given doctor are on his "list." The following demonstrates the capitation fees by size of list.

Income from General Patients

Size of List	Income in Pounds	Dollar Equivalent
1,000	1,163	$3,256.40
1,500	1,888	4,286.40
2,000	2,325	6,510.00
3,500	3,638	10,186.40

The maximum number of patients per general practitioner is 3,500.

OTHER INCOME SOURCES

A physician may derive additional income from a number of other sources, such as a bonus for practicing in rural areas, payments for emergency treatments, payments for the treatment of temporary residents, fees for vaccination and immunization, fees for private practice, fees for maternity cases, and salaries as hospital staff members.

The base compensation for hospital medical staff specialists is:

Medical consultants—from $5,880 to $8,680

Senior medical officer—from $4,200 to $5,460.

In addition, distinction awards are made to consultants in recognition of special contributions to medicine, exceptional ability, or outstanding professional work (other than administrative). The awards are at three rates:

	Rate
A awards	2,500 pounds ($7,000) a year
B awards	1,500 pounds ($4,200) a year
C awards	500 pounds ($1,400) a year.

Four percent of the total number of consultants may be given A awards; 10 percent, B awards, and 20 percent, C awards. As there are now about 7,220 consultants in Great Britain, the numbers eligible for the various classes of awards are as follows:

A award — 289
B award — 722
C award — 1,444.

Below the posts of specialist status—consultants and senior hospital medical officers—is a series of

(Continued on page 48)

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(Continued from page 46)

posts, ranging from the junior house posts, in which all newly qualified doctors must now spend at least a year as provisionally registered practitioners, through the senior house posts and registrar posts, to the senior registrar posts. Most of the holders of the senior registrar posts become consultants or senior hospital medical officers in due course.

Although the posts are of limited tenure, it is common in the junior grades for a doctor to take a series of posts in the same grade before obtaining a post in a higher grade or leaving the hospital service for other medical work.

The salaries range from $2,382.80 for a junior hospital medical officer to $4,312 for a senior registrar with four years in grade.

A special committee studying the methods of remuneration recommended the encouragement of group practice and in 1953 established an interest-free loan program to assist groups in obtaining and adapting central facilities.

The Ministry of Health reports that a better distribution of physicians is gradually being achieved. The average number of patients per doctor decreased from 2,450 in 1952 to 2,250 in 1957.

Following are the questions we put to the Ministry of Health, and the Ministry's answers.

Q. How is the National Health Service Financed?

A. The national Health Service Contributions Act, 1957, which came into operation on September 2, 1957, introduced a small weekly contribution, but the amount collected covers only about one-ninth of the estimated cost of the National Health Service. The remaining expenditure is a charge on the national income, just as the armed forces and other necessities are. It is not an insurance scheme. Most of the cost of running the service is paid out of the national exchequer, from taxes, though a small contribution toward the cost is made from the National Insurance Fund, and some of the expenses fall on the local rates.

Q. Does obtaining treatment under the Health Service depend upon payment of contributions?

A. Any person residing in the country is entitled to use the National Health Service, whether or not he pays contributions. Children and elderly persons, for example, do not make contributions but are eligible for treatment. If you, a visitor, became sick, you could avail yourself of the services.

Q. Supposing a person desired to have a family doctor who was not a member of the service. Could he do so and still use other elements of the service?

A. A person is free to use all or any part of the service as he prefers. For instance, if he has a private physician and it becomes necessary for him to have an operation, his doctor may refer him to a hospital in which, if he chooses, he may be treated as a National Health Service patient.

However, a person attended by a private physician is not entitled to medicines under the service and must pay for them in full. The reason for this regulation is that the prescription and supply of medicines is regarded as an integral part of the family doctor arrangements.

Q. Does the patient have freedom of choice of a physician?

A. The patient chooses his doctor, but the doctor in his turn, in rare cases, may refuse to take a person on his list. One reason for this provision is that there is a limit to the number of patients a doctor is allowed to accept under the service (3,500); so it may be that a second choice will have to be made. A patient may change his doctor at once if he has changed his address or obtained permission of the doctor on whose list he is. Or he may make a change by informing the local executive council (in which case a 14-day delay is usual).

Q. Can a patient obtain services while traveling?

A. When a person is away from home—on holiday, or traveling on business—he can go to any doctor in the National Health Service for treatment, under arrangements especially made to insure that temporary residents can take part in the program.

Q. With charges for a wide number of services, can the Service be classified as free?

A. Despite the introduction of charges in connection with some branches of the service, the total recovery from patients is estimated to amount to about five percent of the cost of the service as a whole.

Q. What charges are now made for dental visits?

A. Dental examination is still free. In addition, all persons under 21, expectant or nursing mothers, and all patients treated in the hospital are exempted from the treatment charge, while provision is also made for those to whom a charge would cause hardship. A charge, when made, covers a course of treatment which may involve a number of visits.

Q. Are all drugs obtainable under the National Health Service?

A. The doctor is entitled to prescribe under the service any drugs or medicines which he considers necessary for the treatment of a patient, but he may not order things which are not drugs or medicines, such as foods or toilet preparations. He may order dressings and other items normally used in general practice, as set out in the regulations. Most surgical appliances are supplied through the hospital service.

A doctor whose prescribing appears to be unreasonably costly may have to justify it to colleagues on the local medical committee, subject to appeal to independent referees. He may have money withheld from his remuneration if he fails to justify his prescribing.

(Continued on page 51)

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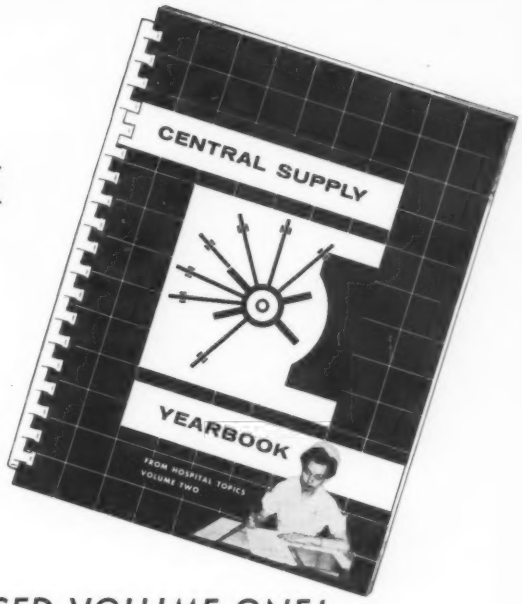

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SCHEDULE FOR: MANAGER AND WORKING SUPERVISORS ☒ OTHERS ☐ PERIOD: _____

GROUP	POSITION	EMPLOYEE	MON	TUES	WED	THUR	FRI	SAT	SUN	MON	TUES	WED	THUR	FRI	SAT	SUN
Administrative	Manager, Housekeeping Services	Roy						x	x						x	x
Day Porter	Leadman-Porter	George			x	x									x	x
Hospital Maid	Hospital Housekeeper	Jean						x	x			x	x			
Administrative	Office Records	Open						x	x						x	x
Special Cleaning	Leadman-Spec. Clean	Mal	x							x						
Night Porter	Leadman-Porter	Sam							x						x	
Serviceman	Leadman-Serviceman	Lorn					x									x
Hospital Maid	Maid - Training	Odessa						x								x
	Maid - Training	Maude							x						x	
	Maid - Training	Tom						x								x
	Maid - Training	Edith							x						x	
Linen Room	Leadman-Linen	Arthur				D									D	D
	Attendant-Linen	Fenner						D	D				D			
	Attendant-Linen	White							D						D	D
	Seamstress	Cooke			D			D	D			D			D	D
TOTAL			10	11	10	10	10	6	5	10	11	10	10	11	5	5

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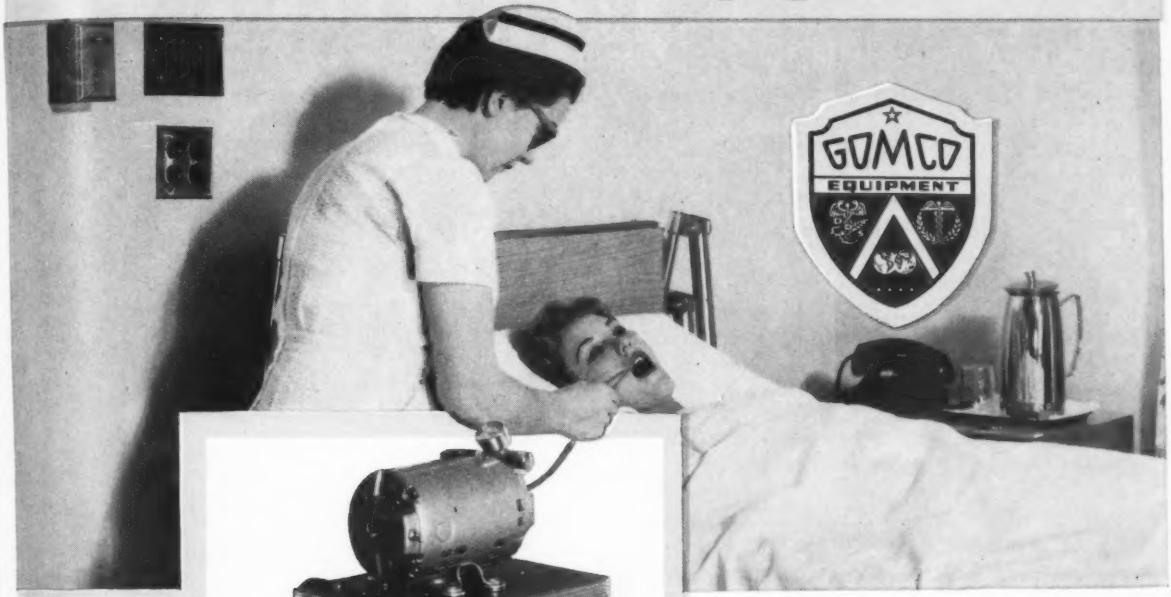

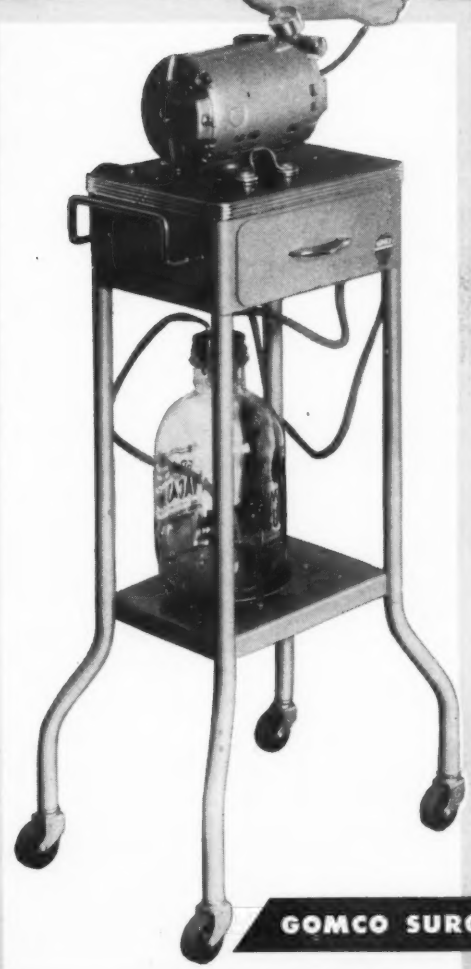

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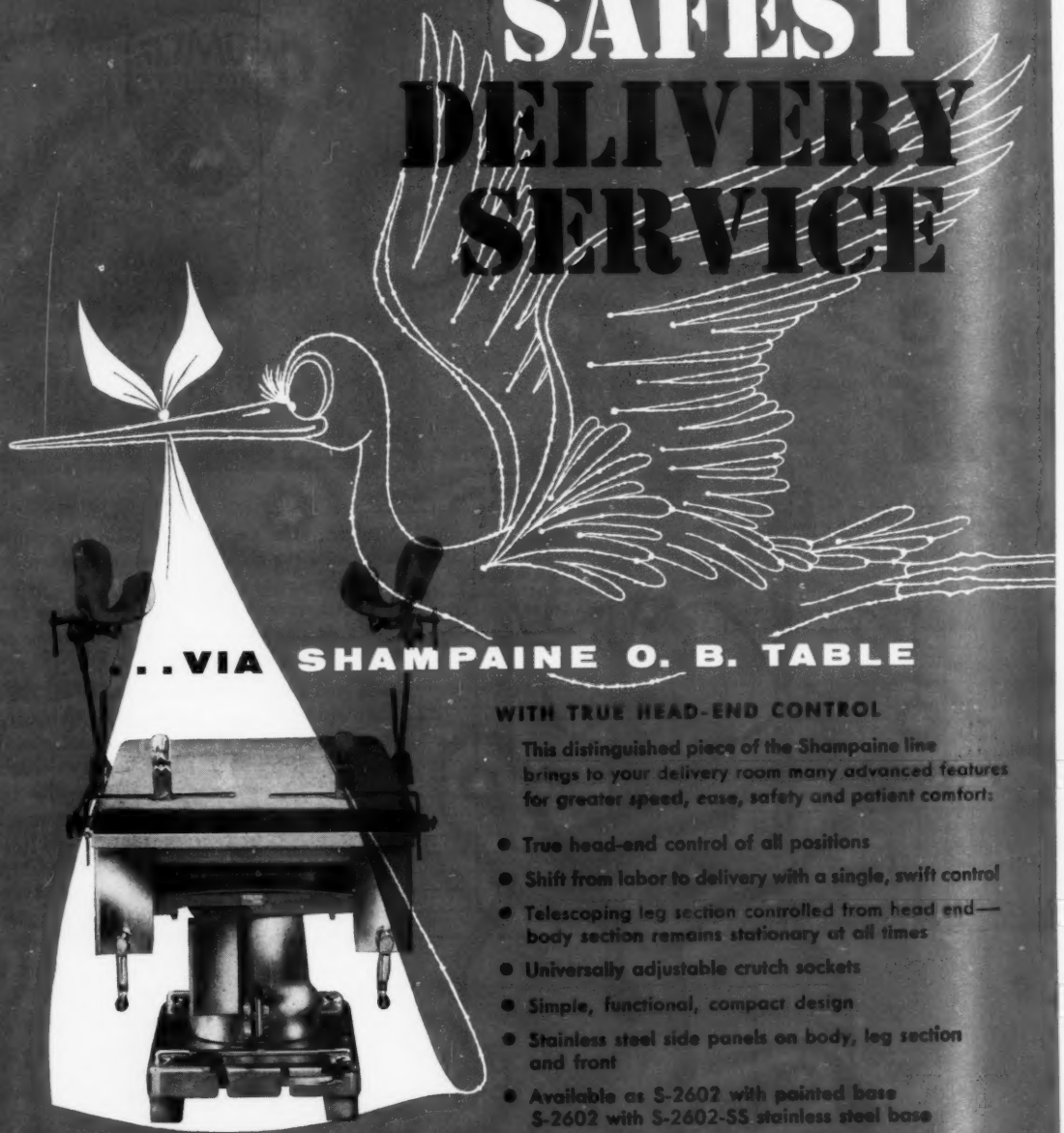

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(Continued from page 48)

Q. Is it true that patients are not getting proper treatment because of too great demands on the National Health Service?

A. It is true that at the beginning there was a rush on the National Health Service—both to doctors' and dentists' surgeries as well as to hospitals. This was to be expected, because many persons who could not afford treatment before July, 1948—particularly women and children—were getting it for the first time.

In most instances, however (such as the great number of requests for spectacles and appliances), the long waiting lists have been overtaken. In addition, more beds have been opened in hospitals—about 30,000 since the start of the service—and the total nursing and midwifery staff in hospitals has increased by about 23,000 full-time and 14,000 part-time members.

Q. Is preventive medicine being given a proper place in the program?

A. The fact that no financial barrier bars people from seeking early advice and going to the doctor means that many cases of serious illness are being treated earlier than ever before. The diphtheria immunization campaign has continued unabated. The record of eight deaths in 1956 was a marked decrease from 156 deaths in 1948 and 2,641 deaths in 1941, when the campaign started. Work continues with whooping cough vaccine, BCG vaccine against tuberculosis, cold cures, and other preventive agents.

Perhaps the main development in the field of preventive health under the National Health Service has been the widening of the health visitor's responsibility. Formerly she was chiefly concerned with giving health advice to mothers and young children. Now she is concerned with the preservation of the health of the whole family and precautions against the spread of infection, and she is also the family's link with any other service it may need.

Q. What proof can you offer that the National Health Service is a success in Great Britain?

A. The fact that about 97 percent of the people in England and Wales have chosen a doctor within the service, that nearly all doctors, dentists, opticians, pharmacists, and other medical personnel have joined, and that for the first time a great many people are receiving all necessary medical care speaks for itself.

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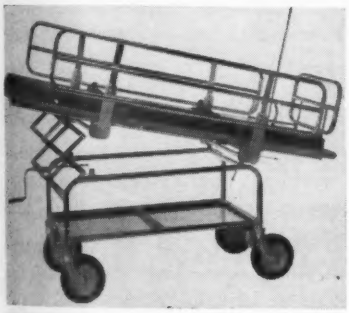

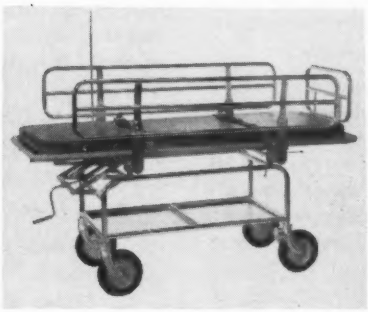

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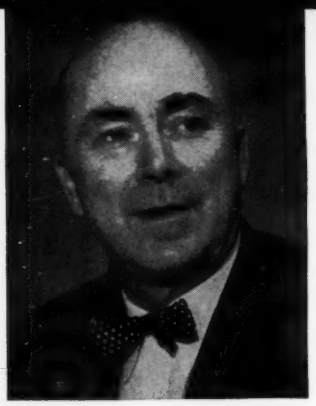

Hospital Housekeeping

Another in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

● The housekeeping department is often referred to as the "forgotten area of the hospital." If some housekeeping problem cannot be resolved at a lower level, it is brought to the attention of the administrator. Otherwise, he seldom becomes concerned with this activity.

Actually, the housekeeping department is one of the most important functions in the hospital. Consistently the approach to housekeeping has been negative. Now, after years of indifference, hospitals are suddenly becoming alert to the importance of this activity, and because of a negative reason—the danger of staphylococcic infections.

It has often been said that most patients judge the hospital by the quality of the housekeeping, the tastiness of the food, the attitude of the receptionist, and the length of the back rub. Like it or not, this is largely true; these are the things that the patient feels—and is—qualified to observe and judge.

The housekeeping department is responsible for keeping the physical plant clean and orderly, and sometimes for supplying clean linen to the nursing service and other departments, both in as economical a manner as possible. This department's work encompasses the daily maintenance of all floors, corridors, patient rooms, bathrooms, office areas, service areas, public areas; the control and disposal of refuse daily; also, the maintenance, on a project basis, of walls, doors, lighting fixtures, windows, Venetian blinds, and entranceways to the building.

The housekeeping department may also be responsible for operation of elevators, for the distribution of service supplies to the nursing divisions and service departments, and for the linen room operation and the operation of the sewing room, as was pointed out in the discussion of the laundry (HOSPITAL TOPICS, April, 1958, page 36).

ASSIGNMENT OF RESPONSIBILITIES

The housekeeping department usually is operated under the direction of an executive housekeeper. In the smaller hospital, approximately 150 beds, the executive housekeeper may report to the plant superintendent or to the hospital administrator. In the larger hospital, 200 beds and over, the executive housekeeper usually reports to an assistant administrator who is responsible for the service departments.

In hospitals which schedule cleaning for several work shifts, assistant housekeepers are assigned the responsibility for the work to be done on the respective shifts. These assistant housekeepers report to the executive housekeeper. When the size of the hospital warrants it, foremen or group leaders are assigned for different groups of employees, such as floor porters, nursing division maids, and wallwashers. The foreman or group leader reports to the assistant housekeeper in charge of the area.

This system is also used when the linen and sewing rooms are the responsibility of the housekeeping department; foremen or group leaders in these areas assume responsibility for the daily operation and they, in turn, report to the assistant housekeeper in charge of these operations.

ORGANIZATIONAL PROBLEM AREAS

Studies of housekeeping departments have found that organizational problems usually result from one or more of the following shortcomings:

——*Failure to define clearly the lines of interdepartmental responsibility and reporting relationships.* For example, the distribution of clean linen to its point of use in the hospital may be the responsibility of the housekeeping department, while the collection of soiled linen and its processing is the responsibility of the laundry department. Usually, in such cases, the lines of responsibility between the departments are not clearly defined. The ultimate responsibility for having the required amount of clean linen available throughout the hospital when it is needed is assumed by neither department.

——*Failure to define clearly lines of intradepartmental responsibility and reporting relationships.* For example, housekeeping floor porters may be confused as to whether they report to their group leader, the assistant housekeeper, or the executive housekeeper.

(Continued on page 54)

*Director of Research, Project W-34, U. S. Public Health Service, San Diego, Calif.

Figure I: Flow Process Chart

SUMMARY	NO.	TIME (Min)	DIST.
OPERATIONS ○	8		
INSPECTIONS □			
MOVES ⇨	9		64'
DELAYS D			
PERM. STORAGE ▽			
TEMP. STORAGE ▽	3		
TOTAL	20	15.49	64'

PRESENT METHOD [x] PROPOSED METHOD [ ]

SUBJECT CHARTED: Cleaning Patient's Room (2 bed room) (218 sq. ft.)

DEPT.: Housekeeping

EQUIPMENT, TOOLS, etc.: Dust mop, sponge, wet mop, buckets, dolly, mop squeezer

ANALYST: _____

NO.	DESCRIPTION	ACTIVITY	DIST.	TIME
1	Porter transports cleaning equipment to patient's room	○□⇨D▽	20'	0.58
2	Porter picks up dust mop	○□⇨D▽		
3	Porter enters room	○□⇨D▽	4'	
4	Porter dust mops patient's room	○□⇨D▽		
5	Porter reaches for dustpan	○□⇨D▽	4'	
6	Porter sweeps soil into dustpan	○□⇨D▽		
7	Porter transports dustpan to wastebasket	○□⇨D▽	10'	
8	Porter empties dustpan	○□⇨D▽		
9	Porter transports dustpan and dust mop to corridor	○□⇨D▽	4'	
10	Porter places dustpan and dust mop in corridor	○□⇨D▽		2.75
11	Porter prepares dusting sponge for use	○□⇨D▽		
12	Porter enters room	○□⇨D▽	4'	0.20
13	Porter dusts window sills, chairs, doors, dresser, bed and bedside stands	○□⇨D▽		4.36
14	Porter returns dusting sponge to corridor	○□⇨D▽	4'	
15	Porter places dusting sponge in pail	○□⇨D▽		
16	Porter prepares wet mop	○□⇨D▽		
17	Porter enters patient's room	○□⇨D▽	4'	
18	Porter wet mops patient's room	○□⇨D▽	10'	
19	Porter transports mop to pail	○□⇨D▽		
20	Porter places mop in pail	○□⇨D▽		7.60

(Continued from page 52)

——*Failure to assign employees to specific duties.* This results in a confused, ineffective operation, in which some jobs are being done by nearly all the employees, and other jobs are not being done at all.

One solution to the organizational problems of the housekeeping department lies in making a careful analysis of work performed by it. The analyst should conduct interviews with the supervisory personnel and employees of the department to determine the assigned functions, reporting relationships, and lines of supervision within the department. In the case of interdepartmental relationships, it is necessary to determine the assigned functions of each department and the means of communication between departments. Where there is confusion of duty assignment or reporting relationships, or a duplication of functions, the situation must first be dealt with individually, then as part of the whole organization.

MANAGEMENT CONTROLS

Kinds of Information Needed

General information about the operating detail of the housekeeping department is useful in making a broad evaluation of the operation. Such information concerns the number of personnel employed, the total area maintained, and the labor and material costs accrued. Once this basic information is obtained, the average area in square feet maintained by each employee can be determined by dividing the total area of the hospital by the number of personnel. Experience has indicated that, in a well-planned housekeeping department, one person can effectively clean from 7,000 to 8,000 square feet of patient area, and from 20,000 to 30,000 square feet of space in which patients are not located.

Data on labor and material costs accrued make it possible to determine the annual labor cost per square foot by dividing the total annual labor cost by the total hospital area in square feet; and the annual cost of supplies per square foot by dividing the total annual supplies cost by the total area, in square feet, of the hospital.

The total area in square feet maintained by each employee, the annual labor cost per square foot, and the annual materials cost per square foot represent broad categories for evaluating the operation of the housekeeping department. Often, it is desirable to gather additional information regarding the details of work done by the department. This information may be obtained with relatively little difficulty since many of the cleaning assignments performed are of a repetitive, routine nature—the same assignment is performed every day, usually at the same time, by the same person, using the same method of operation, and the same equipment and supplies.

Units of Work Performed

The cleaning responsibilities of the housekeeping department may be divided into the following general classifications or units of work:

1. Cleaning private areas such as private rooms, nursing stations, utility rooms, and other service areas on the nursing divisions.

2. Cleaning corridor floors on nursing divisions and in service areas.

3. Cleaning public areas such as lobbies, rest-room facilities, and waiting rooms.

4. Cleaning office areas such as administrative offices, business offices, and admitting offices.

5. Cleaning service areas such as the laboratory, the x-ray and dietary departments, and the pharmacy.

6. Cleaning walls, ceilings, and doors (vertical areas).

7. Cleaning special areas such as light fixtures, Venetian blinds, and exhaust ducts.

Work Productivity

Since the cleaning responsibilities of the housekeeping department can be subdivided into clearly defined units of work, detailed operational data may be developed for each category. The following operational data are desired:

1. The total area cleaned in each of the categories.

2. The total number of cleaning personnel assigned to each category and the assignments performed by each of them.

3. The total labor cost per day for each category.

4. The total supplies cost per day for each category.

Using this data, it is possible to determine the following information regarding work productivity in the housekeeping department:

1. Average area in square feet maintained by each employee per category and per total hospital.

2. Average labor cost per square foot per category or per total hospital on a daily, weekly, monthly, or yearly basis.

3. Average supplies cost per square foot per category or per total hospital on a daily, weekly, monthly, or yearly basis.

4. The ratio of number of cleaning personnel to number of beds.

5. Total cleaning cost per square foot for each category and for the entire hospital on a monthly or yearly basis.

Application of Controls

This operational data will assist the executive housekeeper in exercising greater management control.

The data will be helpful to (a.) recognize areas of high cost of operation; (b.) spot problem areas im-

(Continued on page 56)

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(*Continued from page 54*)

mediately, before complex operating difficulties arise; (c.) recognize excessive labor and supply costs.

The operational data are not an end in themselves, however. They present factual information which can be used by the department head and the hospital management to evaluate, periodically, broad aspects of the operation of the department.

Since effective direct personnel supervision is often difficult to provide for the entire hospital, other devices in addition to collection of operational data, are necessary to assure maximum production for funds expended for housekeeping. The principal mechanism for achieving this goal is called cost and production control.

COST AND PRODUCTION CONTROL

Although operational data provide the department head and management with factual information upon which to evaluate the operation of the housekeeping department, information also is needed on the work method, and the equipment and supplies used in performing cleaning assignments. It is imperative to determine how these items can be combined most effectively to obtain maximum results for each dollar invested in housekeeping. Such a determination can be made by the establishment of a cost control program.

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A cost control program is composed of the following six segments for which standards and procedures must be devised:

1. Work quality—standard of cleanliness required.
2. Work output—standard cleaning procedures.
3. Standard time data—standard amounts of time for performing cleaning procedures.
4. Work supervision—training and follow-up of employees, and output and quality of work maintained.
5. Work supplies—standard equipment and supplies required.
6. Work interest—development of employee interest and morale.

Work Quality

The first step required to establish an active cost control program is to determine the standard of cleanliness to be maintained in every area of the hospital. The standard should be determined by the housekeeping supervisor and the supervisor of the area being evaluated. It is necessary to know how clean an area must be kept before it is possible to develop the method to be used in cleaning the area, the equipment and supplies required, and the time of day and frequency of performing the cleaning operation.

The standard of cleanliness for every area should be recorded for use in determining the standard cleaning procedure, and as a guide for the housekeeping supervisor in evaluating the results of the cleaning assignment.

Work Output

After determining the standard of cleanliness for each area throughout the hospital, the next step in the cost control program is to develop the most effective cleaning method for achieving the standard. The following steps are required to develop a standard cleaning procedure:

1. Prepare a flow process chart of each cleaning method presently performed.

The flow process chart is a graphic representation of the sequence of all operations, transportations, inspections, and storages occurring during a job or procedure. It clearly portrays elements of work and brings to light many previously unknown facts about the operation. An example is shown in Figure 1 (page 53) which presents a flow process chart of the present method of cleaning a two-bed patient room. The flow process chart is used in the housekeeping department, as in the laundry department, to analyze the details of the various jobs.

2. Analyze the flow process chart of each cleaning procedure to determine if eliminating, combining, or changing the sequence of the operation will improve efficiency.

Consideration always should be given to eliminating or simplifying the job through new or revised

(*Continued on page 58*)

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(*Continued from page 56*)

use of a piece of equipment. Upon completion of the analysis, if a change in the process seems indicated, a flow process chart of the proposed method should be constructed.

In the analysis of the present cleaning procedure, various types of equipment and supplies should be tried and evaluated and those best suited to performing the proposed cleaning method ultimately selected.

3. Determine the actual time required to perform the cleaning assignment.

Once the job is broken down into its elements by means of flow process analysis, the time required to perform each element may be obtained by means of a time study, using a stop watch.

Each employee has his own rate of speed or pace in performing a job. Adjustments must be made in the actual time individual employees require to perform the job to reach the figure representing how long it takes the normal operator to perform the job if he works at a normal rate of speed. The resulting time of performing the job is referred to as the "normal time required" to perform the job.

Time allowances are added above and beyond the normal time required to perform each cleaning assignment. For example, in cleaning assignments performed in a nursing division, the following allowances are provided:

——Process allowance—5 percent: for interruption in the procedure, such as if a doctor or nurse enters the patient's room while the maid is cleaning.

——Personnel allowance—8.5 percent: for time required to travel to and from the work area and 15-minute rest periods in the morning and afternoon.

——Fatigue allowance—5 percent: to allow for slow-down resulting from fatigue as the day progresses.

The time study procedure used in the housekeeping department is the same as that used in the laundry department. It is possible to use the same method because the jobs found in both departments are of a repetitive nature.

4. Determine the frequency of performing the cleaning assignment.

Certain cleaning assignments, such as the cleaning of office areas, should be performed daily. Others should be performed more often, such as the maintenance of public rest-room areas. Still others, such as the washing of walls and the cleaning of light fixtures, should be performed weekly, monthly, quarterly, or yearly. The frequency of performing the cleaning assignment should be determined by the standard of cleanliness established for the area under consideration.

5. Determine the time of day the cleaning procedure should be performed.

In many hospitals in the past, a majority of the cleaning assignments were performed during the day shift. Then, many hospitals began having personnel on the afternoon shift clean the service areas of the hospital, such as the laboratory, x-ray, dietary, and administrative areas. This was a step in the direction of efficiency because it permitted the employee to clean the area without constantly being interrupted by personnel working there.

The establishment of an afternoon shift, however, creates scheduling problems; also it does not permit the most efficient utilization of employees' time because the service areas are in operation during a portion of the afternoon shift. Recently, many hospitals have established night cleaning staffs for cleaning all service areas of the hospital. This program has been quite successful; it permits the cleaning staff to be used effectively for the entire shift because all of the areas in which they work are completely vacated during the cleaning operation.

Many advantages are derived from having a night cleaning staff. In one hospital, the laundry was formerly cleaned immediately after it closed for the day. The working area was quite warm, creating undesirable working conditions. The laundry is now cleaned during the night shift. The equipment and general area have cooled down, thus improving working conditions. The change in the time of cleaning the laundry has resulted in greater productivity.

6. Develop schedules of personnel requirements for the cleaning categories in the hospital.

After determining the cleaning method, the tools and supplies to be used, the standard time required to perform the assignment, and the frequency with which the assignment should be performed, it is possible to determine the number of cleaning personnel required for each category.

For example, to determine the personnel requirements for cleaning the patient areas of an average hospital floor, the unit and total times for each operation for each day of the week are listed. After project work time is added in, personnel requirements for each day, and for the week, for that category, can be determined.

Developing Standard Time Data

At the end of this article, a summary is presented of standard time data for performing the elements of one of the cleaning procedures found in the housekeeping department. Such standard time data are developed in the following steps:

1. Each cleaning procedure, such as cleaning a patient room, is broken down into its elements.

2. Time studies are conducted on the elements of each of the cleaning procedures. Sufficient time studies are taken until the element times are consistent.

3. The average element times are determined.

4. Each operator is rated, and the normal time required to perform the procedure is calculated.

(*Continued on page 60*)

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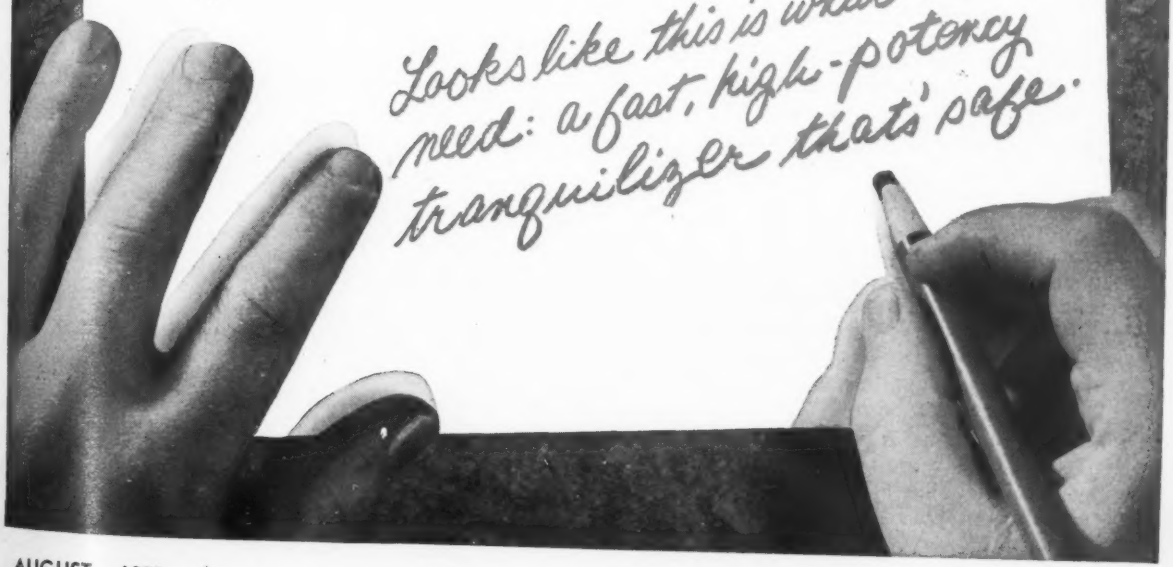

(*Continued from page 58*)

5. The area, in square feet, is determined, and the normal time required to clean one square foot of area is calculated.

The resulting standard times *do not* provide allowances for personal fatigue or delays. Usually 18.5 percent of the normal time required is added for these allowances.

The standard time data may be used to (a.) determine the standard time required to perform a cleaning procedure, such as cleaning a patient's room; (b.) determine the number of cleaning personnel required to perform a cleaning procedure; (c.) assist the supervisor in scheduling employees' time and in evaluating the efforts of individual employees.

Once standard production data have been developed regarding the cleaning methods to be used and the number of cleaning personnel required for the various areas in the hospital, the pertinent information should be transmitted to the employees assigned to carry out the procedure.

It is important to remember that the application of standard time data to the operations of the housekeeping department is not a substitute for direct supervision. Standard time data will assist the supervisor in carrying out the responsibilities of the department, but will not reduce the need for personal attention.

Work Supervision

The next phase to be considered in the establishment of a cost control program for the housekeeping department is work supervision. The housekeeping supervisor is the key to the success of a cost control program. She has a threefold responsibility in the development and application of a cost control program:

1. She participates in the development of the standard procedures.

2. She is responsible for training the employee in new cleaning procedures through the use of instruction cards.

3. She is responsible for obtaining results from the program, through her direct, on-the-job supervision.

Direct supervision is particularly important in the housekeeping department because many of the employees are scattered throughout the hospital and are often left to themselves to complete their assignments.

A cost control program will not substitute for direct supervision. However, the mechanics of supervision are greatly simplified when it is possible to provide the employee with an all-day assignment, showing the jobs to be done, the methods to be used, the equipment and supplies required, and the time required to perform the work.

The supervisors must insist on quality in the work produced. Not only must she see that the job is completed on time, but also that the quality of the work meets the standards of cleanliness previously established.

Housekeeping supervisors, in most instances, are responsible for the training of all housekeeping personnel. In the large hospital, a training director may be available within the department for conducting both formal and on-the-job instruction. Employee training includes both types of instruction.

The initial step in the formal training program is the selection of specific employees for the assignments outlined in the standard cleaning procedures. The employees are given a series of instruction cards corresponding to their assignments. These instruction cards contain the following information about each job: the operation or procedure; the area where the operation is to be performed; a step-by-step, detailed breakdown of the procedure; precautions

(*Continued on page 62*)

Figure 2

Instruction Card

Operation: Damp mopping business office floor
Area: Business office (Rooms #191, #193) (590 sq. ft.)
Procedure:

1. Obtain equipment and supplies and proceed to housekeeping workroom (west hospital entrance).
2. Place 3 gallons of water in both mop buckets.
3. Add 4 ounces of liquid detergent to each bucket of water (2 full measuring glasses).
4. Transport mop equipment to business office.
5. Remove portable equipment from office.
6. Dust mop business office floor, using 12-inch dust mop.
7. Fill dustpan and empty into wastebasket.
8. *Damp mop* business office floor *one time.*
9. Wait for floor to dry.
10. Replace portable equipment in office. (Be sure to locate all equipment as it was found.)
11. Transport mop equipment to housekeeping workroom (west hospital entrance).
12. Empty buckets and rinse mop and buckets.

Precautions:

1. Be careful not to splash water on side walls when squeezing mop.
2. Remove all spots, stains, and gum from the floor.
2. Replace all equipment to its original location after cleaning.

Equipment: Mop, wringer, dolly, 2 buckets, one 12-inch dust mop, one dustpan, one quart of liquid detergent, and one 2-ounce measuring glass.

Time required: 0 hours and 50 minutes.

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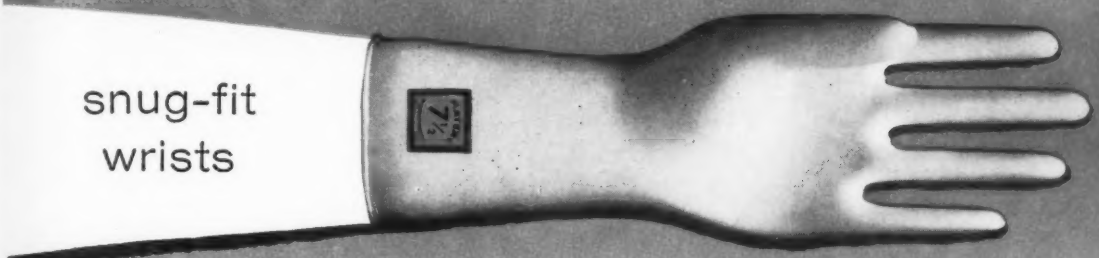

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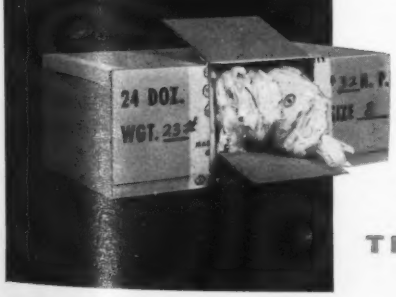

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(*Continued from page 60*)

concerning the operation; the equipment and supplies needed; the time required.

The instructions are detailed and simply written so that the employee responsible for performing the procedure will have little doubt regarding what is to be done, where it is to be done, how to do it, what equipment to use, and how long it should take to do.

After the employee has been formally instructed in the details of the procedure, he is given on-the-job training to supplement the formal teaching. The instruction cards are retained by the employee as a permanent record of the work which has been assigned to him.

Figure 2 (page 60) shows a sample instruction card, giving the standard cleaning procedure, in a typical hospital, for damp mopping the business office floor.

Work Supplies

The next phase of the cost control program is concerned with determining work supplies and equipment. Selection of the proper equipment and supplies to be used in performing a cleaning procedure is most important if a hospital is to obtain effective utilization of its cleaning personnel and facilities. Housekeeping supervisors must be constantly on the alert to uncover new cleaning materials and equipment as these become available on the market. Controlled study programs should be conducted by the housekeeping department to determine whether standard cleaning methods should be changed, or a new piece of equipment adopted, or a new cleaning product substituted for the one being used.

Once an active cost control program has been put into operation, the evaluation of new housekeeping supplies and equipment is greatly simplified. When complete information regarding the time required to perform a cleaning procedure and the frequency of its performance are readily available, an analysis of any new piece of equipment or supply may be made in a minimum amount of time, and the findings based on fact rather than opinion.

A procedure should be developed to cover the ordering and stocking of cleaning and sanitary supplies. Normal or average consumption data should be available. These data will serve as a guide for determining the proper quantity usage for each area in the hospital and will tend to minimize losses.

Consumption for cleaning materials may be based on square feet and for sanitary supplies, on the number of occupants. With this data, the housekeeping supervisor can readily detect excessive usage of any of the items. Detection of an abnormally high rate of usage of cleaning materials may be a clue that a standard cleaning procedure is not being followed.

Maximum and minimum stocks to carry, based on usage and ordering frequencies, should be determined by the housekeeping department in conjunction with the purchasing department.

Work Interest

The last phase to be considered in the establishment of a cost control program is work interest. It has been proved that the work interest among employees performing cleaning assignments greatly improves in a department in which the method of performing the assignment has been standardized, the employee has been given the required equipment and supplies, and ample storage space for equipment and supplies has been provided.

Work interest also may be increased by establishing an incentive system based on the production standards developed in the cost control program. The incentive system provides a means of compensating the employee for the work he actually performs. A presentation of the various incentive compensation programs was made in the article on the laundry (HOSPITAL TOPICS, May, 1958, page 47).

The following list is an example of a set of standards for a hospital housekeeping department:

Area: Patients' Rooms

Operation	Minutes per Unit	Work Unit
1. Dust mop patient's room, fill and empty dustpan		
a. private room	1.00	100 sq. ft.
b. 2-bed room	1.26	100 sq. ft.
c. ward	1.00	100 sq. ft.
2. Damp dust with sponge		
a. chair	0.38	1 each
b. dresser	0.60	1 each
c. bedside stand	0.40	1 each
d. bed	0.85	1 each
e. window sill	0.10	1 each
f. screen	0.45	1 each
3. Damp mop patient's room		
	M. & F.	T., W., Th., S.
a. private room	2.75	2.75 100 sq. ft.
b. 2-bed room	4.50	3.48 100 sq. ft.
c. 4-bed ward	4.18	3.42 100 sq. ft.
d. 6-bed ward	4.15	3.12 100 sq. ft.
e. 12-bed ward	2.85	2.85 100 sq. ft.
4. Transport equipment between patients' rooms	0.58	

SUMMARY

The cleaning operation of the housekeeping department lends itself to the development of management and cost controls. Controls are not an end in themselves, but provide factual information for the supervisor's use in carrying out the responsibilities of the department.

The establishment of standards of cleanliness and work output are required if cost control is to be effectively maintained. However, direct supervision must be exercised if the cleanliness and work output standards are to be met.

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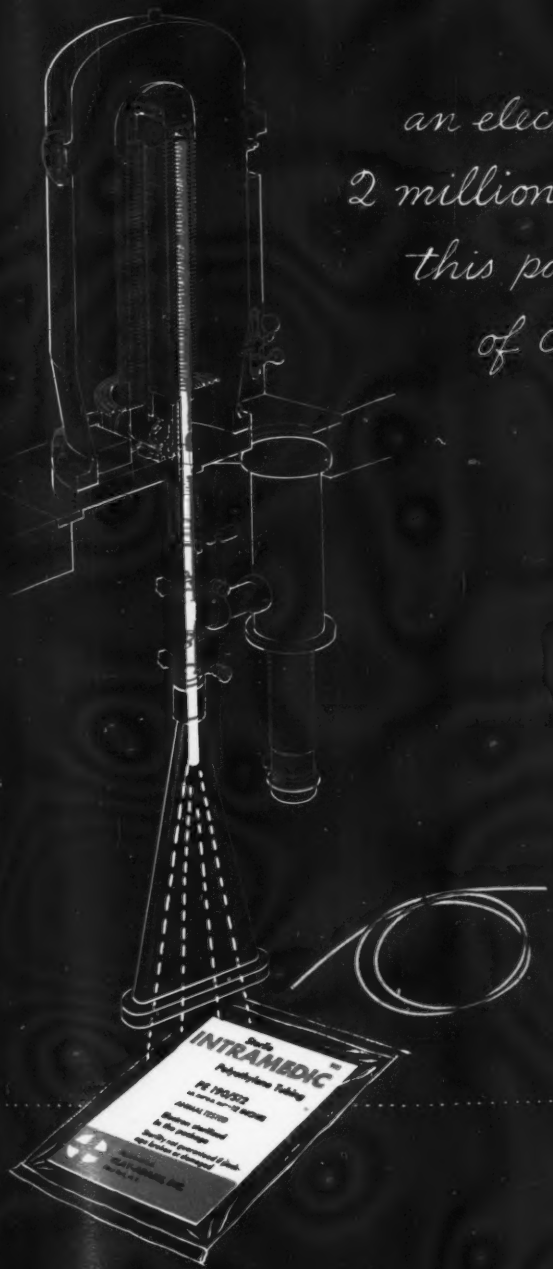

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		15
PE-160/S12 & PE-160/S36	18	13
PE-190/S12 & PE-190/S36	18	14 thin wall
PE-200/S12 & PE-200/S36	17	13
PE-205/S12 & PE-205/S36	16	12
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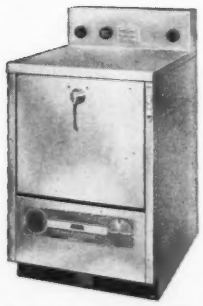

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Above, left: A young student interested in business office procedure, uses a billing machine for the first time, while her classmates wait their turn. Center: A high school boy helps weld a broken tool handle. All moving parts on equipment and supplies in the hospital are on calendar maintenance. The boys also learned about special water treatment, boiler room operation, and general repairs on hospital equipment.

Teenagers participating in the Careers-that-Count Youth Day at St. Luke Hospital, Fort Thomas, Ky., actually learned to operate and care for machines and equipment used in the various departments. Above, right: In the dietary department, students helped prepare special diets, created balanced menus, and served their colleagues a typical teenager lunch of hamburgers, french fries, cole slaw, milk, and cake.

172 Kentucky High School Students Study Hospital Operation in Youth Day

ST. Luke Hospital, Fort Thomas, Ky., gave 172 boys and girls from nine northern Kentucky high schools a chance to study hospital operation at close range when it sponsored a Careers-that-Count Youth Day during National Hospital Week.

Itineraries were planned to give students an opportunity to help run the hospital for one day in the departments of their choice, under the supervision of department heads. Six nurses, normally off duty, augmented the regular staff to assure adequate patient care while the head nurses lectured.

By 9 a.m. of Youth Day, the students had been absorbed into all departments of the hospital. At day's end, the following results were noted:

Hospital personnel were highly enthusiastic, commenting especially on the lack of confusion, the interest and attentiveness of the students.

Horizons of the students were expanded, and many myths and misconceptions exploded. Twenty-two students confirmed their career choices: one x-ray technician, two pharmacists, two business office workers, 15 registered nurses, and two practical nurses. The hospital received 15 applications for summer jobs.

Two casualties were reported. One high school student fainted because she forgot to eat breakfast. One student nurse was "lost" while watching a patient being sutured in the emergency room.

"We learned," says R. Arthur Carvolth, administrator, "that a hospital *can* carry on its normal functions while explaining its operation to a group of this size. To prepare detailed schedules for each department took a lot of planning, but we all feel it was well worth it, and we hope to do it again next year."

Below, left: St. Luke's housekeeper shows a student how to combine efficiency and speed in mending hospital linen, explaining that all linen, including special sheets for operating and delivery rooms, is this department's responsibility. The most popular spot with girls on the nursing itinerary was the obstetrics department. Right: Students cuddle infants in the professional manner.

Regional Differences in U. S. Hospitals

Eighth in a series

By Louis Block, Dr. P.H.

● There are regional differences in the numbers and kinds of hospital facilities and services available, and in their utilization. The role of the regional hospital can best be portrayed by studying it as a part of the total United States picture, and as an entity in itself.

The largest amounts of total assets in:

1. All hospitals are in the Middle Atlantic region.

2. Short-term general hospitals are in the Middle Atlantic region.

3. Nonprofit short-term general hospitals are in the Middle Atlantic region.

4. Proprietary short-term general hospitals are in the West South Central region.

5. Governmental (excluding federal) short-term general hospitals are in the Middle Atlantic region.

6. Long-term general hospitals are in the Middle Atlantic region.

7. Psychiatric hospitals are in the Middle Atlantic region.

8. Tuberculosis hospitals are in the Middle Atlantic, South Atlantic, and East North Central regions.

9. Federal hospitals are in the Middle Atlantic region.

Most of the total assets in all regions are concentrated in short-term general hospitals. In this group, the nonprofit controlled hospitals have the largest share.

In the West South Central region, the proportionate share of total assets in proprietary and governmental (excluding federal short-term general hospitals) is greater than in other regions. Proportionately, the Mountain region has a higher share of its total hospital assets in federal hospitals than do the other regions.

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.

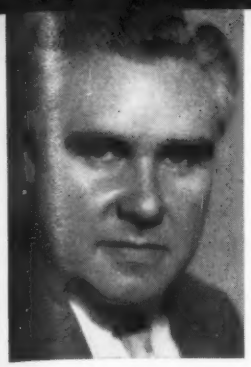
*Total Assets**

1. The Region as a Part of the United States

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	8.3	26.6	12.1	20.2	4.4	8.7	7.1	3.3	9.3	100.0
Short-Term General	9.0	26.6	11.1	21.0	4.2	8.9	7.3	2.9	9.0	100.0
Nonprofit Short-Term General	11.0	29.6	9.2	23.1	3.1	8.8	5.3	2.8	7.1	100.0
Proprietary Short-Term General	1.1	11.0	19.4	5.6	11.7	5.2	29.4	3.0	13.6	100.0
Gov'tal (Excl. Federal) Short-Term General	3.3	18.7	16.3	15.9	6.9	9.5	11.6	3.2	14.6	100.0
Long-Term General	9.1	41.7	9.9	16.7	2.5	4.7	3.5	2.3	9.6	100.0
Psychiatric	8.3	27.1	11.1	25.2	3.3	10.5	5.1	2.2	7.2	100.0
Tuberculosis	6.4	20.2	20.6	20.4	8.7	6.5	3.9	4.8	8.5	100.0
Federal	5.7	21.7	16.3	11.3	5.9	7.6	11.0	6.7	13.8	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	63.1	58.6	53.1	60.6	55.8	59.5	60.1	50.6	56.1
Nonprofit Short-Term General	57.6	48.6	33.0	49.7	31.1	44.1	32.9	36.5	33.2
Proprietary Short-Term General	0.2	0.5	2.0	0.3	3.3	0.7	5.2	1.1	1.8
Gov'tal (Excl. Federal) Short-Term General	5.3	9.5	18.1	10.6	21.4	14.7	22.0	13.0	21.1
Long-Term General	5.3	7.6	3.9	4.0	2.8	2.6	2.4	3.3	4.9
Psychiatric	18.6	19.0	16.9	23.1	13.9	22.5	13.5	12.0	14.4
Tuberculosis	3.4	3.4	7.5	4.5	8.8	3.3	2.4	6.4	4.0
Federal	9.6	11.4	18.6	7.8	18.7	12.1	21.6	27.7	20.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0



Consultant's Corner

By John G. Steinle

Q. Do you know of any authoritative statement of policy on press releases, particularly one that distinguishes between emergency cases and routine admissions?

A. The best statement I know about that originates from an official source, is the one prepared by the Great Britain Ministry of Health for all hospitals in that country. Following are the pertinent paragraphs:

"Sickness Cases

"2. Information should not be divulged to the Press without the consent of the patient beyond the statement that the person named in an enquiry is a patient. Where, however, even this statement would be deleterious to the patient's interests, his presence in the hospital should not be disclosed without his consent. For example, in certain special hospitals, such as mental hospitals and sanatoria, where the mere admission of the patient implies the nature of the diagnosis, no information should be given to the Press without the patient's consent, and that of the doctor in charge, who should satisfy himself that to give the information would not be prejudicial to the patient's interests.

"3. In the case of well-known people (and subject always to the patient's consent), a brief indication of progress may be given, in terms authorized by the doctor in charge.

"4. In the circumstances referred to under 2 and 3, where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

"Accident Cases

"5. (a) Individual Cases. The Press should be given, on enquiry only and at the time of the enquiry or as soon as possible afterwards, the name and address of the patient and a general indication of his condition, but not necessarily a diagnosis. The patient's relatives should, if possible, be informed before any statement is given to the Press; but if it has not been possible to do so, this should be made clear to the Press. Further information should be given only with the patient's consent. Where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

"(b) Multiple Cases. In accidents involving a number of people (for example, a railway or air accident) all reasonable steps should be taken to ensure that relatives of the injured have been informed before the publication of names, bearing in mind the necessity of early publication to dispel the anxiety of the next-of-kin of all other persons who were, or might have been, involved in the accident. Further information should be given only with the patient's consent. Where the patient is too ill to give his consent, or is a minor, the consent of the nearest competent relative should be obtained.

"6. Hospitals admitting accident cases should maintain a casualty book or other similar records by reference to which enquiries may be answered."

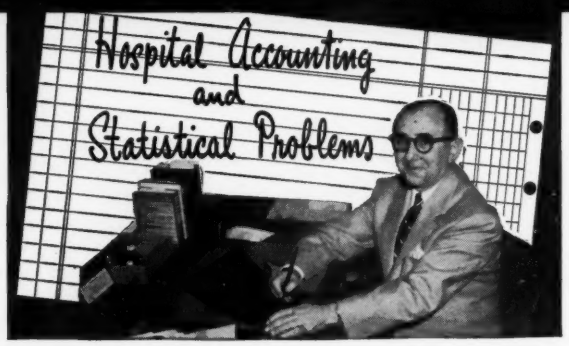
This procedure also outlines various measures for dealing with press inquiries, and recommends that a sufficiently experienced and responsible officer should be nominated in each hospital for this purpose. Finally, the statement observes that satisfactory co-operation between hospitals and the press depends on the observance of conduct that would promote mutual confidence and good personal relations.

Q. Is it feasible to center all the authority for governing a hospital's medical staff in a medical board and have bylaws written only for that board?

A. Definitely not. The bylaws must apply to the entire medical staff. The entire theory of medical organization in a hospital is that the staff, within defined limits, is a self-disciplining group. Bylaws that apply only to the "governing body" would not have the support and participation of the entire medical staff. Such support is necessary if the staff is to function effectively.

Q. What major precautions should be taken when oxygen is used other than not smoking and avoiding open flames?

A. The most common cause of oxygen fires is spontaneous combustion. This frequently occurs when the oxygen somewhere in the system comes in contact with grease. A clue to this connection is the relatively high number of oxygen fires that occur after meals. Employees handle oxygen equipment, and check valves and connections immediately after they have eaten, without carefully washing and rinsing butter and other grease from their hands. Careful rinsing of hands after washing is important because soap can also cause spontaneous combustion. It must be remembered that only a trace of carbohydrate coming in contact with an oxygen jet can cause combustion.



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. The doctor in charge of our laboratory is paid a percentage of the laboratory fees received. Our books are kept on an accrual basis. When there are short payments from Blue Cross, how would you recommend that payments to the doctor be handled?

A. The most equitable solution that we can think of in such a situation is to prorate the allowance, or short payment by Blue Cross, over the entire bill, and decrease the earnings from the laboratory by their prorata share. For example, if the entire bill consisted of the following—

Laboratory Fees	$ 35
B.B. and R., etc	140
	$175

and Blue Cross paid only $160, then 20 percent of $15, or $3, would be deducted from the laboratory earnings.

This procedure would prevail where Blue Cross paid a flat rate on a per diem basis. If the Blue Cross plan in your area specifically limits the laboratory charges, the allowance would of course have to be charged to the laboratory unless otherwise noted.

Q. Would you please comment on the factors which determine whether a patient balance due to the hospital is to be charged to allowances or the reserve for bad debts.

A. Allowances, in our experience, fall into one of the following categories:

1. Discounts to patients, clergy, medical staff, or others.

2. Discounts to third-party agencies by special contract.

3. Allowances to patients by the administration at time of admission or during their stay in hospital, because of economic reasons.

Bad debts would be those accounts which were deemed to be collectible upon the patient's discharge from the hospital, but which the hospital could not collect and had to write off.

We recognize the difficulties which arise in establishing a line of demarcation between these two categories, but if the foregoing policy were instituted, we believe that greater understanding would prevail in the accounting office.

Q. Is it practical to confirm outstanding accounts in voluntary hospitals? If so, to what extent would you recommend confirmation in the following categories:

1. Discharged patients with no insurance coverage

2. Patients still in the hospital

3. Compensation cases

4. Blue Cross cases.

A. Our practice is to confirm outstanding accounts during the course of audit. At times this is done at the time of closing, or the balance sheet date, and at other times a spot confirmation is made during an interim audit period. The following procedure is carried out for the categories mentioned:

1. All discharged cases without insurance coverage are contacted directly.

2. Since the date of the audit is usually after the close of the month, either the latter part of the following month, or later, we test-check these account cards.

3. Compensation accounts are confirmed with the carrier. It is found on some occasion that cases deemed to be compensable are disputed and claim must be instituted against the patient.

4. Blue Cross cases are checked with payments received. We find at time of audit that explanations are required if the Blue Cross agency has not made payment to the hospital.

Q. I always earned more than $4,200 each year until I retired in July, 1954. I was under the impression that I should receive the maximum social security benefit of $108.50 a month. However, I receive only $98.50 a month. Can you tell me why?

A. The benefits you receive are based on the average of $3,600 a year. This was the maximum earnings under the social security coverage from 1951 through 1954. In order to be eligible for $108.50 a month, you must have earned $4,200 a year for at least two years after 1954.

Q. Can you tell us how long we must keep the following accounting records? Storage space has become a problem, yet we do not want to destroy material which may be required at a later date.

1. Charge tickets

2. Census sheets

3. Creditors' invoices

4. Checks.

A. Charge tickets are usually kept through the end of the fiscal year and audit period, since supporting data is on the patient's chart and account card. Census sheets are also kept through the fiscal year and audit period. Prime accounting and financial records are usually kept for as long as required by the statute of limitations in your state. We would suggest that this information be obtained from a local attorney by your board of trustees.

Review of Hospital Law Suits

Not Subject to County Zoning Law

By Leo Parker
Attorney at Law

• A higher court recently rendered an important decision to the effect that a city or county ordinance is invalid and unenforceable if it is not approved *or* if it contradicts a state law.

In Davidson County v. Harmon Construction Co., 292 S. W. (2d) 777, a county attempted to enforce its zoning ordinance against the state in the construction of a mental health building. It was alleged that the health building, because of its height, would be a menace to a municipal airport. The higher court held that the property owned by the state, on which they are going to build a public building for governmental purposes, is not subject to county zoning ordinances. The court said:

"The state is not subject to the zoning ordinance or building code of a city or county."

NEED NOT PROVE INEFFICIENCY

Considerable discussion has arisen from time to time among physicians, surgeons, and hospital officials over the legal question: Can the government lawfully confiscate drugs not proved to be effective for treatment of a disease claimed by the manufacturer and seller to be good for this purpose?

According to a late higher court decision, the answer is yes.

In United States v. Wood, 226 Fed. (2d) 924, the testimony showed that the Government seized certain drugs known as "Diabena." The plaintiff's statement alleged that the drug had been shipped in interestate commerce; that the descriptive literature became associated with it after its interstate shipment; and that it was misbranded and subject to condemnation because the accompanying label falsely represented that the drug would be effective in the treatment of diabetes.

In other words, the main contention of the Government was that the manufacturer and seller falsely claimed that the drug would be more effective than insulin in the treatment of persons suffering from diabetes.

The lower court held that the Government could not legally seize and confiscate the drug "Diabena" because no proof was given that it would not produce better results than insulin.

During the trial two experts testified about experiments which they conducted with "Diabena" by administering it to rabbits, the official test animal for insulin in the U.S. Pharmacopoeia. The tests were the same as those used to determine the effect of insulin on diabetes or the lowering of blood sugar. The experts explained that a drug which would reduce the level of blood sugar in rabbits would reduce the level of blood sugar in human beings, and that results of these tests showed that "Diabena" had no more effect in lowering blood sugar than did water.

The higher court reversed the lower court, approved the seizure, and said:

"We think the Government has clearly established its case by a preponderance of the evidence. The judgment of the District Court is, accordingly, reversed and the case is remanded to that court with instructions to enter judgment in favor of the United States. Finally, we observe that it might indeed be difficult to find a diabetic who would act as a guinea pig by abandoning insulin over any substantial period of time and submitting to treatment by 'Diabena' or any other drug whose efficiency has not been established. Diabetes is a serious disease which, if not properly and promptly treated, tends to become increasingly dangerous."

AMBULANCE HAS RIGHT-OF-WAY

A higher court recently held that the driver of an ambulance of an emergency call is justified in assuming that other automobile owners will hear his siren and not enter an intersection, irrespective of whether the traffic light is green or red.

In Martin v. City, 285 S. W. (2d) 778, it was shown that an ambulance went through a red light and caused damage to a police automobile.

In subsequent litigation it was proved that the skid marks laid down by the ambulance were 72 feet long. Basing his opinion on the length of skid marks, Officer Bibb concluded that the ambulance was going about 40 miles per hour at the point of collision.

The higher court, in holding that the corporation owner of the ambulance was not liable for damages to the police car, said that the testimony showed that the ambulance driver was sounding his siren loudly and might reasonably expect that no vehicle would emerge into the intersection but would yield the right of way to the oncoming ambulance, which was visible and audible for a block and a half from the intersection.

(Continued on next page)

SURGEON NOT AGENT OF HOSPITAL

Recently a higher court held that although a physician or surgeon is on the hospital staff, the hospital never is liable for negligence of the physician or surgeon unless the testimony clearly indicates that he acted as "agent" for the hospital. Also, in this late case, the higher court held that in legal suits involving negligence, a jury must make the final decision.

For illustration, in Mayers v. Midway Hospital, 316 Pac. (2d) 351, the testimony showed these facts:

Mrs. Mayers first met Dr. Litow in 1951 when he performed a hysterectomy on her. In 1952 he removed her gallbladder. She had had a nodule on her neck for several years; however, she had never experienced any trouble with her neck or throat. Upon examining her prior to the gallbladder surgery, Dr. Litow noticed the nodule on her neck and advised thyroid surgery. He was of the opinion that it was serious and required surgery because it was a "premalignant lesion."

Since the gallbladder surgery and the thyroid operation could not be undertaken at the same time, Dr. Litow decided to carry out the planned gallbladder operation first, and perform the other surgery after Mrs. Mayers had recuperated. Certain tests were made before the thyroid surgery. He did not tell her that her ability to speak or breathe would be affected by the operation.

Mrs. Mayers entered Midway Hospital for the thyroidectomy. She was examined by a medical student, who made notations on her hospital record concerning her physical examination and case history.

An important point of this suit is that Dr. Litow was on the staff of the Midway Hospital and used it for many of his operations. He made the arrangements concerning Mrs. Mayers' time of admission and operation, leaving the financial arrangements with the hospital to be made by Mrs. Mayers and her husband.

Before the operation, at the request of Dr. Litow, Dr. Pies visited Mrs. Mayers at the hospital and examined her vocal cords. He found them to be normal in appearance and mobility. She was given sedatives in the evening and the next morning Dr. Litow performed the operation with Dr. Feinstein assisting. The latter was engaged by Dr. Litow to assist in the operation. Dr. Feinstein was also on the staff of Midway Hospital. Both doctors testified that there was nothing unusual about this operation and that no complications were observed. The tumor in the thyroid gland was removed, and was later found not to be cancerous.

After the operation Mrs. Mayers complained of difficulty in speaking and breathing, and she continued to be very hoarse. Mrs. Mayers sued both Dr. Litow and Midway Hospital for heavy damages, claiming that, during the operation, Dr. Litow had negligently cut the laryngeal nerve, which caused her present discomfort.

During the trial, Dr. Pies testified that he examined Mrs. Mayers two days after the operation, and found that the right vocal cord was normal, but that there was an impairment of the left cord of approximately 30 percent. Mrs. Mayers denied having been examined by Dr. Pies at that time. She testified that she did not see him from the time of his visit before the operation until she went to his office for an examination during which he found there was no movement of the left vocal cord. He expressed the opinion that the change was due to the healing and "fibrosis." He was also of the opinion that the difficulty in breathing was not permanent and that her cold contributed to the condition.

In the weeks following the operation Mrs. Mayers went to see Dr. Litow several times. In response to her questions about her hoarseness, he said that it would go away.

Another physician, Dr. Wexler, testified that he first examined Mrs. Mayers six months after the surgery. He found her left vocal cord to be totally paralyzed. By the time of the trial Mrs. Mayers' condition was much improved.

HOSPITAL NOT LIABLE

It is interesting to observe that the higher court held Midway Hospital not liable in damages to Mrs. Mayers although the testimony showed that Dr. Litow performed the surgery with the assistance of Dr. Feinstein, and that both doctors were on the staff of Midway Hospital. In this respect, the higher court said:

"There is nothing in the record from which it may legitimately be inferred that Dr. Litow or Dr. Feinstein was an agent or employee of the hospital. The doctors merely used the hospital facilities to perform the operation. It does not appear that they received any remuneration from the hospital for their services."

The higher court held that Dr. Litow might be liable in damages to Mrs. Mayers if the testimony showed that during the operation he severed the recurrent laryngeal nerve. In this respect, the higher court said:

"In support of their second theory of negligence, Mrs. Mayers introduced extensive evidence tending to show that Dr. Litow might have severed the recurrent laryngeal nerve during the operation. Since all the medical experts were of the opinion that this nerve should not be severed during the type of operation performed upon Mrs. Mayers, a severance of that nerve would indicate that the doctor failed to exercise reasonable care in performing the operation. If there was sufficient evidence indicating that Dr. Litow severed the nerve then the case should have been allowed to go to the jury."

Personally Speaking

The 1958 class in hospital administration at the Army Medical Service School poses in the Quadrangle at Brooke Army Medical Center. Left to right, back row: Maj. Kenneth G. Howard, Lt. Col. John A. Mikuluk, Lt. Col. Murray F. Evans, Maj. Hugo K. Koch, 1st Lt. Carlos A. Soto, Maj. Vernon E. Case, Maj. Jack L. Flora, Maj. Frederick S. W. Whittington, Maj. Jordan L. Epperson, 1st Lt. Richard E. Woodruff, Capt. Robert A. Watson, 1st Lt. Dean S. Holman, Maj. Dudley P. Cook, Capt. Frank S. Tarantino, 1st Lt. Joaquin R. Carvajal, Capt. John Atkins, Lt. Col. Wade F. Hampton, Maj. Edward M. Strobel, Col. Wang Tze Peung, Lt. Col. Chris D. Hoover.

Middle row: Lt. Col. Julian J. Fried, Capt. Albert M. Meyer, Maj. Martin J. Carr, Capt. James B. Culbertson, Maj. Matthew Ginalick, Maj. Joseph C. Burgio, Maj. Floyd E. Van Sickle, Lt. Col. Agha Fakhar Hussain, Maj. Dave C. Clark, Lt. Col. Orne D. Smith, Lt. Col. Robert F. Lerg, Capt. Harold Diehl, Jr., Lt. Col. James E. Lewis, Col. Ali Parmoon, Lt. Col. Lee Kiyoon, Maj. William S. Beck.

Front row: Lt. Col. Albert B. Hunt, chief, comptroller branch, department of administration; Capt. Eileen B. Witte; Maj. Rita A. Cleveland; Col. William A. Hamrick, director, department of administration; Brig. Gen. Elbert DeCoursey, school commandant; Lt. Col. Sam A. Edwards, chief, command and management branch, department of administration; Mrs. Rose T. Nigrelli, instructor; Maj. Rubye W. Archer.

Olga Benderoff, R.N.—will become director of nursing, University Hospitals, Cleveland, O., on January 1, 1959, replacing **Ann C. Deeds, R.N.**, who has resigned.

Miss Benderoff will also become professor of nursing, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland. A former Army Nurse Corps lieutenant colonel, she has been director of nursing, Cuyahoga County Hospital, Cleveland, since 1955.

Howard L. Borchardt—has been named credit manager, Yakima Valley Memorial Hospital, Yakima, Wash., succeeding **Earl C. Waters** who resigned to become administrator, New Valley Osteopathic Hospital, Yakima.

Alexander D. Cobbin—has become administrative assistant, University of Washington Hospital, Seattle. Previously he was assistant director, Vancouver (B.C., Canada) General Hospital.

Douglas Contos — has been appointed business manager, Louis A. Weiss Memorial Hospital, Chicago.

Maurice P. Coffee, Jr. — has been named assistant administrator, Shadyside Hospital, Pittsburgh, Pa. He was formerly at Lankenau Hospital, Philadelphia, where he was awarded the postgraduate training grant of the American College of Hospital Administrators for 1957-58.

Harold Dunsky — Chicago fund raiser, has been appointed executive director, Development Fund, Mount Sinai Hospital, Miami Beach, Fla. The new Mount Sinai hospital, now under construction, is scheduled to open in the spring of 1959.

Mrs. K. Elizabeth Erickson, R.N.—has been appointed nursing supervisor, the University of Washington Hospital, now under construction in Seattle.

Other nursing appointments announced by the hospital include: **Elizabeth Byerly, R.N.**, nursing supervisor, pediatrics; **Harriet Falck, R.N.**, formerly outpatient supervisor, University of California at Los Angeles, nursing supervisor, outpatient division; and **Betty Korte, R.N.**, formerly assistant operating room supervisor, King County Hospital, Seattle, nursing supervisor, operating room division.

Also named to the staff of the hospital are: **Helen W. Waterman,** chief medical records librarian, and **John Werner,** supervisor, machine accounting and statistics. **Shirley Bowing,** formerly director, School of Occupational Therapy, College of Puget Sound, Tacoma, Wash., will be chief occupational therapist at the University hospital and will head a teaching program. She has also been appointed head, division of occupational therapy, department of physical medicine and rehabilitation, University of Washington.

(*Continued on next page*)

Charles F. Farnsworth—has been appointed administrator, Nassau General Hospital, Fernandina Beach, Fla. He had been administrator, Highland County Hospital, Hillsboro, O.

R. E. Golliet—has been appointed business manager, Morton (Wash.) Hospital.

CLASSIFIED

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

Pittsfield Bldg., 55 E. Washington St.

Chicago 2, Illinois

POSITIONS OPEN

EXECUTIVE PERSONNEL: (a) Controller—business manager. Near Chicago. Good background in hospital accounting. $7,800. (HT-3008). (b) Personnel director. Southwest. 500-bed hospital. (HT-2195). (c) Administrative assistant. California. Responsible for admitting, accounts receivable, and medical record functions in 225-bed teaching hospital. $6,000 minimum. (HT-2238). (d) Office manager—accountant. South. 200-bed hospital. Degree with major in accounting preferred. Will train to take over as administrator, as present incumbent is retiring in near future. (HT-2025). (e) Director of business management. State board of health. Degree in accounting plus public health or business administration experience. To $11,000. (HT-2091).

CLINICAL PSYCHOLOGISTS: (a) East. Public mental hospital. Ph.D. plus 4 years' experience including research and teaching. To $9,454. (HT-2118). (b) Staff position with medical agency caring for exceptional children. $8,000. (HT-1968). (c) South. Clinical and experimental research with children who have central nervous system dysfunctions. Will have faculty appointment in medical school. (HT-2071). (d) Psychology consultant. State department of mental health. Ph.D. required. $7,000 up. (HT-1955). (e) Chief psychologist. South. 2,000-bed hospital. Ph.D. required. $8,000. (HT-2125). (f) Northwest. Large state hospital. Psychological evaluation and psychotherapy. To $8,200. (HT-2177). (g) Southwest. Chief of department in large state hospital. Ph.D. required. $7,500. (HT-2133).

CHIEF OCCUPATIONAL THERAPIST: Southwest. Experienced in the physical disability areas. To administrate three clinics with five sections consisting of pediatrics, general medicine and surgery, psychiatry, tuberculosis, and physical disability. Hospital affiliated with medical school and university. (HT-2198). WE WILL BE IN BOOTH 321 AT THE AMERICAN HOSPITAL ASSOCIATION CONVENTION IN CHICAGO.

NOTE: We can secure for you the position you want in the hospital field, in the locality you prefer. Write for an application—a postcard will do. ALL NEGOTIATIONS STRICTLY CONFIDENTIAL.

Director of Nurses—experience preferred, and one general duty nurse, for a 40 to 50 bed hospital at Amery, Wisconsin, 60 miles east of St. Paul-Minneapolis. Salary open. Contact administrator. Write box HT-8.

Charles R. Goulet—has been named associate director, Johns Hopkins Hospital, Baltimore, replacing **Ladislaus F. Grapski** who is now director, University of Maryland Hospital, Baltimore. Mr. Goulet had been assistant professor of hospital and medical administration, Graduate School of Public Health, University of Pittsburgh.

Emory Nicholas Grubbs—has been named administrator, James Walker Memorial Hospital, Wilmington, N.C., succeeding **Horace E. Hamilton** who resigned to become administrator, Spartanburg (S.C.) General Hospital. Mr. Grubbs had been comptroller and assistant director at the Walker hospital for 12 years.

Randall B. Haas, M.D.—has been named medical officer in charge, U.S. Public Health Service Hospital, Memphis, Tenn., succeeding **Richard H. Smith, M.D.**, who has been transferred to the U.S. PHS division of personnel, Washington, D.C., as chief, professional education section. Dr. Haas was formerly deputy medical officer in charge, U.S. PHS Hospital, Brooklyn, N.Y.

Mrs. Birdie Ghiglione Hamilton, R.N. — superintendent, Willapa Harbor Hospital, South Bend, Wash., assumed additional duties as administrator of Ocean Beach Hospital, Ilwaco, Wash., when the Pacific County Hospital District combined the management of the two institutions. **Eugene Lasater** was formerly administrator of the Ocean Beach hospital.

John A. Harrison—has assumed the duties of administrator, Lynn (Mass.) Hospital, succeeding **Dan Traner** who resigned. Mr. Harrison had been assistant administrator, Truesdale Hospital, Fall River, Mass., since 1955.

Catherine Hartman, R.N. — has been named assistant director of nurses in charge of the operating rooms, Western Pennsylvania Hospital, Pittsburgh. She is a former O.R. supervisor, Philadelphia General Hospital, and for the past two years has conducted a postgraduate course in operating-room nursing at the University of Pennsylvania Hospital, Philadelphia.

Herbert Hopps — has been appointed purchasing agent, Hialeah (Fla.) Hospital, replacing **T. F. Pierce** who moved to California.

Edward B. Jones—has been named assistant administrator, Passavant Hospital, Pittsburgh, Pa. He will act as consultant in charge of coordinating the relocation of the hospital in the North Hills area near Pittsburgh. Mr. Jones was formerly assistant administrator, Sewickley Valley Hospital, Sewickley, Pa.

Milton C. Kennaugh—administrator, Clinton (Mass.) Hospital, has been appointed by the Massachusetts Commissioner of Labor and Industries to a new wage board for clerical, technical, and similar occupations.

Ronald H. Lauterstein—has been named administrative assistant, Maimonides Hospital, Brooklyn, N.Y. Previously he served an administrative residency at the Hospital for Joint Diseases, New York City.

Veronica Mitchell, R.N.—has been named director of nursing service and education, W. W. Backus Hospital, Norwich, Conn.

Robert J. Myers—has been appointed administrator, Riverton General Hospital, Seattle, Wash. The institution, formerly known as the Riverton Hospital for Diseases of the Chest, was a tuberculosis sanatorium for 50 years prior to its recent conversion to a general hospital.

Mrs. Louise R. Harris, superintendent of the sanatorium since 1921, retired in July.

Mr. Myers was previously a resident in hospital administration at Kern County General Hospital, Bakersfield, Calif.

The Northwestern University graduates pictured above are among the recipients of Master's degrees in hospital administration from the university at its June commencement. Left to right, front row: John Bertone, Don Myers, Thomas Streit, In Hae Chung, Charles Letourneau, M.D., director of the university program in hospital administration, Catherine Papaeconomou, James Champer, Viva Marie Leflar, Ivan Corner. Second row: Richard Holladay, Donald Leine, Kenneth Van Bree, John O'Meara, Robert Cunningham, William Locke, Windsor Wilder, John Yoder. Third row: John Leicht, Frederick Hinchee, Earl Raps, Francis Lambert, Richard Heath, Hansel O'Quinn, Delos Bristor, Clifford Lebo, William Stewart. Fourth row: Theodore Kaap, Robert Keller, James Herman, Capt. John Pasch, John Tucker, Lionel Price, Vernon Showalter, Glen Lauth, Charles Sanders. Fifth row: Robert Baylor and Russell Clayton.

George V. Novak, Jr.—has been named administrator, Newport (Wash.) Community Hospital, succeeding **Malcolm Reynolds.** Mr. Novak was formerly administrator, New Valley Osteopathic Hospital, Yakima, Wash. **Kathryn Bush, R. N.,** is supervisor of nursing service at the Newport hospital.

Charles N. Payne, Jr.—has been named administrator, Methodist Hospital, Hattiesburg, Miss.

David T. Riddell—has assumed charge of all fund-raising activities for Saint Barnabas Medical Center, to be built in Livingston, N.J. He is executive officer, Hospital Research and Educational Trust, American Hospital Association, and a former member of the New Jersey Hospital Association's Public Relations Council.

T. L. Ridgeway—is now administrator, Our Community Hospital, Scotland Neck, N.C.

Cyril J. Ruilmann, M.D.—has been appointed director of Texas state mental hospitals. He had been Tennessee commissioner of mental health since 1953, and had served as associate professor of psychiatry, Vanderbilt University School of Medicine, and Meharry Medical College, both in Nashville, Tenn.

In his new position, Dr. Ruilmann will supervise 16,000 mental patients in eight Texas institutions.

William P. Ryan, Jr. — has resigned as assistant administrator, Western Pennsylvania Hospital, Pittsburgh, to become administrator, St. Anthony's Hospital, Rockford, Ill. Before coming to Western Pennsylvania in 1953, he was assistant administrator, Meridan (Conn.) Hospital.

William G. Simmons—has been appointed administrator, Battle Creek (Mich.) Sanitarium and Hospital, where he had been assistant administrator. He is a former staff member, American Hospital Association, and also had served as hospital relations director, Chicago Plan for Hospital Care.

Sister Maria of Assisi, R.N.—formerly administrator, St. Joseph Hospital, Vancouver, Wash., is now operating room supervisor, Providence Hospital, Anchorage, Alaska.

W. David Streeter — comptroller, Jewish Chronic Disease Hospital, Brooklyn, N.Y., has assumed the additional duties of associate executive director of the hospital.

Mary Timmerman, R.N.—has been named to the newly created position of director of nursing services, Western State Hospital, Fort Steilacoom, Wash. She was formerly supervisor, female nursing service.

Charles R. Van Wagenen — has been appointed admitting officer, Children's Hospital, Columbus, O. He succeeds **Beverly Barron** who resigned.

Earl C. Wolf—retired August 1 from his position as administrative assistant and director of purchases, St. Mary's Hospital, Rochester, Minn. A member of the staff since 1939, Mr. Wolf was previously business manager, Indianapolis General Hospital. He plans to live in Fort Lauderdale, Fla., where he will enter the consulting field in hospital stores development and purchasing.

Successor to Mr. Wolf at St. Mary's will be **Irvin J. Mullenbach**, former assistant purchasing agent and stores department manager at the hospital.

Roger White—has been appointed assistant administrator, Morton F. Plant Hospital, Clearwater, Fla. He was formerly employed in the contract sales department, American Hospital Supply Corp.

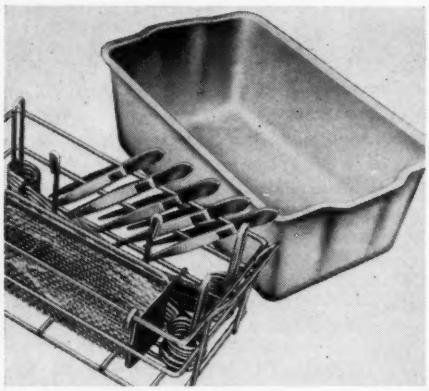
(Continued on page 129)

BUYER'S GUIDE

Ellen Davis

Buyer's Guide Editor

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 136.

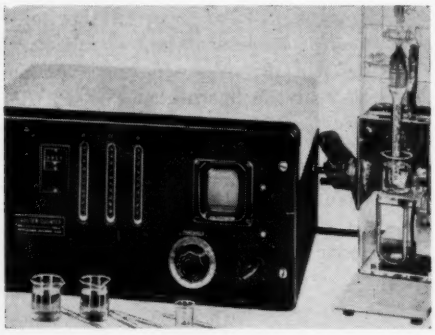


400. Soiled instrument rack

Stainless steel rack-basin combination specially designed for handling and processing soiled instruments on floor or in central supply. Soaking instruments eliminates scouring of caked blood, pus. Rack remains in solution, with instruments in open position, until return to central supply room; there instruments are removed for pre-sterilization prior to washing, sorting, autoclaving. Edward Weck & Co., Inc.

401. Blood-cell counter

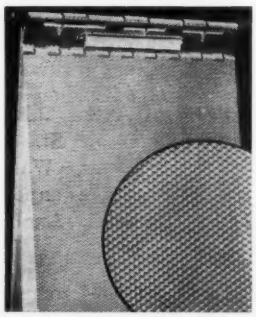
Red and white blood cells counted electronically, each count taking 15 seconds or less plus sample dilution time. Each average count includes 50 cells. Unit automatically takes sample from beaker. Relative cell size and distribution are shown on oscilloscope screen. Scientific Products, division of American Hospital Supply Corp.



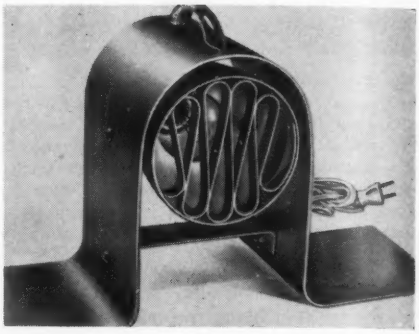
402. EKG Sol

Electrode cream reduces skin resistance by dissolving skin oils for positive contact. Contains a corrosive inhibitor to help maintain electrodes; remains moist for indefinite periods; 2 and 4-ounce plastic bottles with flip spout. Burton, Parsons & Co.

403. Chart Rack



Aluminum chart holder with scratch - resistant surface. Top hanger has riveted card holder. Extension hinges; 9″ x 12″ size, with capacity for ¼″ of record sheets. Professional Specialties, Inc.

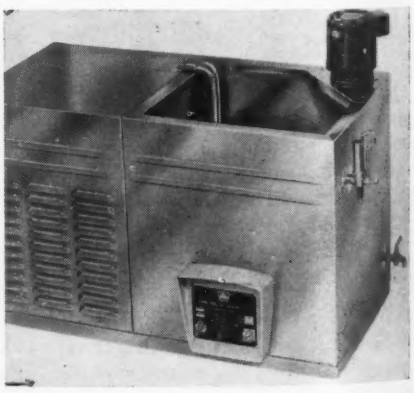


404. Perineal lamp

New perineal lamp has a protective hood across face of lamp reflector, and a hood to protect against warmth of reflector. Weighs 3 lbs. A switch enables patient to control lamp operation. Ellipsoidal reflector pivots a full 60° to direct dry heat to the desired area. The Dann Co.

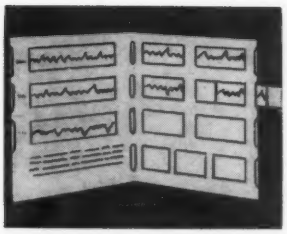
405. Temperature baths

Two new refrigerated and nonrefrigerated constant temperature baths, with temperature range from 0° to 100° C., designed for viscosity tests, physical measurements, aging tests, stability tests, others. Insulated stainless steel, 13″x12″x12″ deep; 8-gallon capacity. Equipped with hermetically sealed F-12 refrigeration compressors and hydraulic thermostat controls. Labline, Inc.



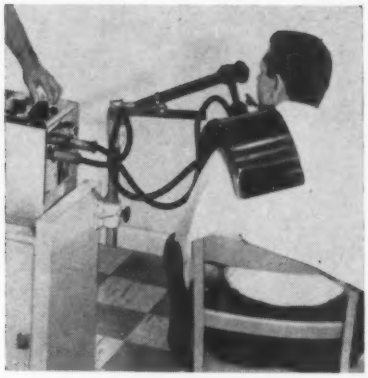
406. One-piece telephone

Ericofon permits bed-ridden patient to make or receive calls without twisting, turning, or straining; light weight and balance reduce fatigue. When instrument is lifted, stand-switch in center is released, putting phone into operation. Putting phone down automatically depresses switch, disconnecting phone. North Electric Co.



408. EKG mounts

Complete line of cardiographic mounts now available in two styles, folder and card. Come in 12 leads for all makes and sizes of electrocardiographic films. Made of durable stock to withstand heavy usage. Film strips slide in and out of mounts easily. Low in cost. Wolf X-Ray Co.

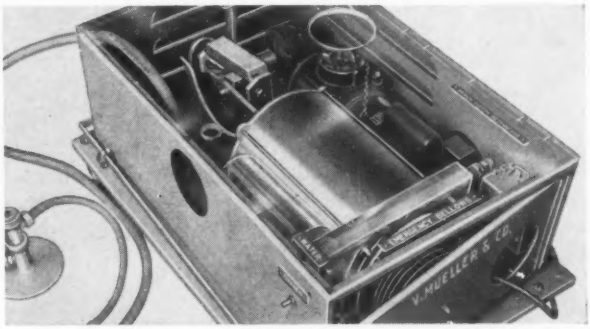


411. Diathermy unit

New unit for all medical diathermy applications, with hinged induction electrode, air-spaced cuff, pad, sinus mask. Meets all FCC requirements with full-wave, rectified power supply. Includes cut-off timer and power switches; condenser treatment pads with connecting cable. Operates on 120V, AC. Rehabilitation Products, division of American Hospital Supply Corp.

407. Non-adhering dressing

New Steripak non-adhering dressing, 2" × 4½", for small wounds that normally stick to gauze, is completely self-contained. Gauze pad is covered with non-adhering film, backed with vented tape for greater aeration to the wound. In sterile, self-dispensing box. Johnson & Johnson.



409. Piston respirator

Operating on large volume, low pressure hyperventilation of patient, respirator produces a state of apnea with safe, mild alkalosis, for internal pneumatic stabilization of the flail chest. Auxiliary hand bellows for therapy during transportation. V. Mueller & Co.

412. TV cart

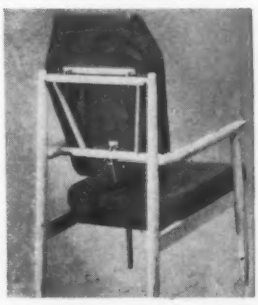
Newly designed hospital TV table of steel tubing with heavy chrome finish. 40" high for from-the-pillow viewing; adjustable for 14" and 17" sets. Reversible side arms eliminate knob interference for sets with side controls. Soft rubber wheels for silent mobility mounted on full swivel, ball bearing casters. Slides under bed when set is not in use, is easily put into viewing position by patient from bed. Guy Hobbs, Inc.

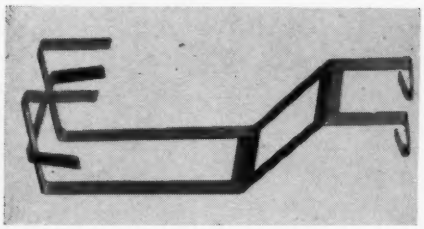
410. Sellevision

Audiovisual aid automatically controls projection for 48 slides, throwing picture on big screen. Any 35mm slide may be used. Complete hi-fi system (including tape recording and playback) assures clarity of instructor's voice. Can be purchased or obtained on long-term lease basis. Hallamore Electronics Co.

413. Patient chair

High-back adjustable chair designed for the convalescing patient. Back section can be adjusted up or down by the patient while seated. Intermediate adjustments for comfort requirements. High seating surface has a low degree of pitch for ease in getting in and out of chair. Fully upholstered foam rubber. Carrom Industries, Inc.





414. Drainage rack

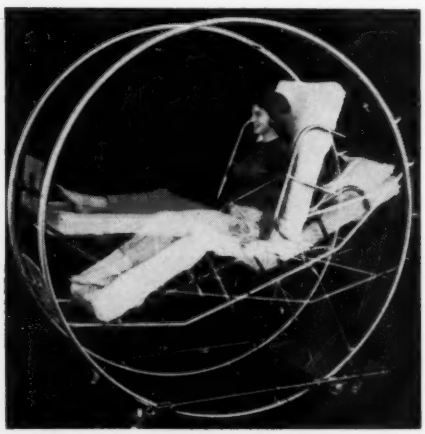
All stainless steel rack hooks on to bed rail; will hold drainage bottles of 1 qt. to 1 gal. capacity. Will not interfere with bed-making; helps keep floor clear and prevent bottle breakage. Beam Metal Specialties.

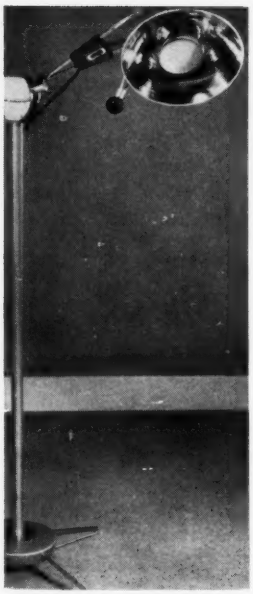
415. Pill dispenser

Nu-Method Pill Pack, a translucent plastic cup with printed tab lid holds up to 12 pills. Printed form on lid has space for patient's name, room number, check-off of hours of medication. Self-contained pack reduces chance of pills being mixed; protective seal is provided when lid is positioned. Caddie Creations.

416. CircOlectric hospital bed

The Stryker CircOlectric Universal bed features many combinations of manual gatching and electrical tilting; a wide variety of reclining, sitting, and vertical positions incorporates features of regular and special beds. Avoiding duplication of equipment, encourages diversionary therapy through self-help, enabling patient to perform many bed operations. Weighs 167 pounds; measures 32″ wide, 84″ long, 78½″ high. Fits all standard elevators and doorways. Orthopedic Frame Co.





417. Surgery light

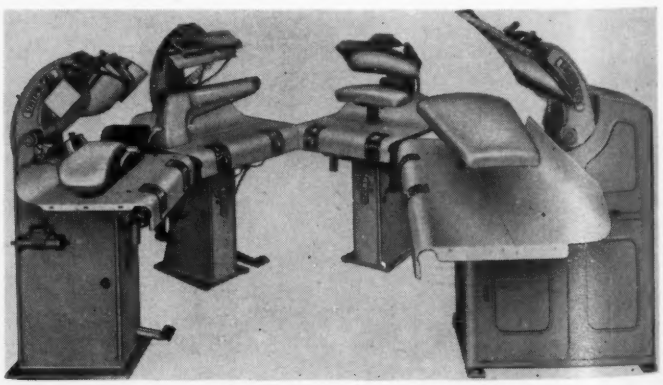
Examination and surgery light with exclusive multi-beam depth of focus. Concentric rings in surface of reflector produce individual cones of light with slightly different focal points. Concentric-cone light eliminates glare and shadows. Wilmot Castle Co.

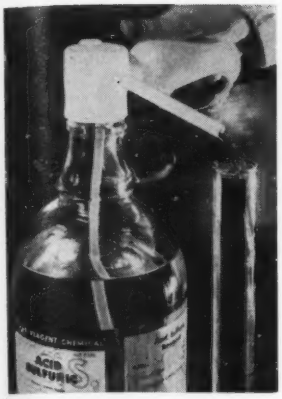
419. Chloride titrator

New Aminco-Cotlove chloride titrator is designed so that concentration of chloride in solution can be rapidly and accurately determined in titration with silver ions. Measures chloride content of serum or plasma, spinal fluid, urine, sweat, saliva, gastrointestinal secretions, culture media, tissues, in five to 60 seconds. American Instrument Co.

418. Laundry presser

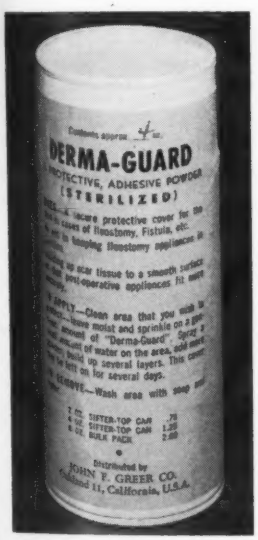
Electric unit for finishing wash apparel of all types has been developed for hospital laundries not having high-pressure steam. Electric elements in both heads and bucks provide fast, even distribution of heat; thermostatic dial controls automatically regulate heat. Unimatic pressure adjusts to thickness differences in garment. A one-girl operation, finishing on the presser reduces extra handling, provides maximum production in minimum space. Unipress Co., Inc.





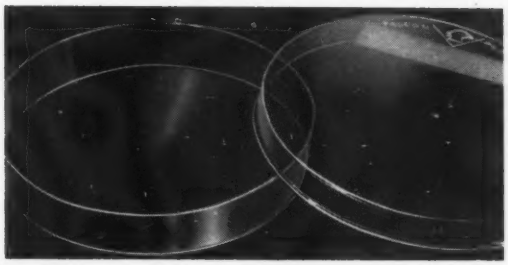
420. Safety acid pump

New polyethylene acid pump screws onto any standard 5-pint acid bottle. Light, rapid squeezes of the unbreakable pump deliver acid at rate of 1,000 ml. per minute. Manual relief-valve button stops flow, with no after-drip. Fisher Scientific Co.



421. Skin protection

Derma-Guard, a new gum karaya powder, serves as an adhesive layer to keep an appliance from slipping, also protects skin from disease waste material. Unlike ointments and silicones, powder may be applied to a weeping surface. Easily removed with dry gauze. 2 and 4-ounce sizes. John F. Greer Co.



422. Plastic Petri dish

Clear-bottom disposable Petri dish of plastic with gateless bottom surface of near optical flatness. Sterile and biologically inert, dish affords free, unimpaired vision, accuracy of bacterial count, uniformly flat surface for microscopic examination of thin layers of material. Falcon Plastics.

423. Plastic cups

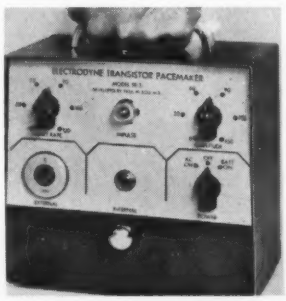
Polystyrene plastic Spir-it medication servers for pills or liquids. May be adapted to freezing single ice cubes. Spir-It, Inc.

424. Break-resistant pipettes

Pipettes of molded Cymac 201, a methyl-styrene acrylonitrile copolymer plastic, have clarity of glass, are break-resistant. Sizes 1.5″ to 3.5″. Calibrations hot stamped or silk-screened on droppers, depending upon the curvature of surface. Plastic Assembled Products, Inc.

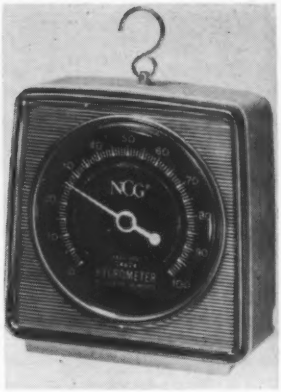
425. Cardiac machine

First commercially available battery-powered, all-transistor electronic cardiac machine, the TR-3 Card ac Pacemaker is completely portable, only 7″ high. Quickly attached to patients, it begins delivering cardiac stimulation within three seconds. Electrodyne Co.



426. Steril-wrap bag

Two-compartment disposable autoclaving bag for sterilizing barrel and plunger of syringe comes in two sizes: 4″x7½″ and 4¾″x8½″. Samples available. Busse Hospital Products.



427. Precision hygrometer

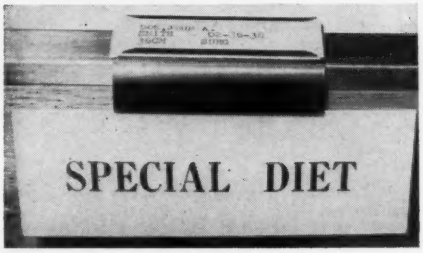
New unit is claimed to be accurate even in atmospheres of 100 percent relative humidity. Hook permits installation over support bar in oxygen tent, open-top or croup tent, or incubator. Can also be used in operating rooms to decrease static electricity by raising humidity. National Cylinder Gas Division, Chemetron Corp.

428. Ice crusher

Automatic unit crushes up to 30 lbs. of ice per minute from any make ice machine. Adjustable control for desired size crushed ice. No knives or picks to clean or sharpen; exclusive safety guard feature. Scotsman, Queens Products, Inc.

429. Germicidal cleaner

Elimstaph #2, a new germicidal floor cleaner, kills staphylococci, enteric, and respiratory pathogens, and fungi on contact, according to manufacturer, by penetrating wall of microorganism and destroying it from the inside. Functions at full strength as long as it remains on the floor or other surface to which it has been applied. Walter G. Legge Co.

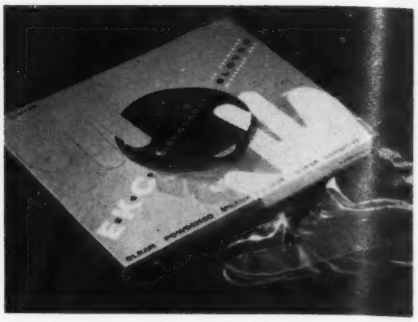


430. Bed marker

New bed marker helps prevent medication and treatment mistakes. Permanently attached with two drive screws, it will not mar or scratch bed ends. Slotted adjustment to fit square or round tubing. Patient-doctor information, on laminated vinyl reminder cards, is easily visible. Stainless steel springfold holds one or two reminder cards. Printing is between layers of plastic, cannot be scratched off, may be cold sterilized. Twenty-six cards are stocked, ranging from "Blood Sugar in A.M." to "Holy Communion." Other titles may be ordered. Design-Rite Products Co.

434. Plastic graduate

Clear, unbreakable plastic. Non-slippery when wet, it will not craze or cloud; liquids will not permeate. Non-tip, non-roll octagonal base. Markings in both ounces and metric measure. In 4, 8, 16 and 32-ounce sizes. Needs Corp.



435. Disposable glove

EKC disposable examining glove in dispenser box is thin, strong vinyl; conforms to fingers, providing tactile sensitivity. Powdered, ready for use. Medium and large sizes. Emergency Kit Corp.

436. Flame-resistant tile

New fire-retardant vinyl tile, manufactured in 80-gauge thickness, in 9" squares, is available for hospital flooring. Inherently stable, it will not curl, flake or crack; resists the direct flame. B. F. Goodrich Flooring Co.

431. Nylon restraint

Safe-Band, of nylon webbing which will not chafe or irritate, can be applied to patient's wrist, ankles or waist. Airplane-type buckle for instant attachment or release. Permits a moderate degree of motion, yet prevents falling from bed or raising arms or legs. Duxe Products.

437. Lightweight exercise mat

Folding Profex exercise mat is lightweight, durable, has unridged working surface. Foam filler will not pack or mat, is resistant to most acids, oils, alkalis. Zipper cover of Fabrilite cleans with damp cloth. Carrying and storage handles, double-stitched. Comes in 8 standard sizes. Professional Specialties.

432. Shower stall mat

Heavy-duty construction Rubbermaid bath-mat for institutional use. Underside pattern of safti-cups clings firmly to shower floor, providing safe footing and reducing liability risks. Size is 22¼"x22¼"; flexible and easy to handle; perforated for quick, complete drainage. Rubbermaid, Inc.

438. Disposable super towel

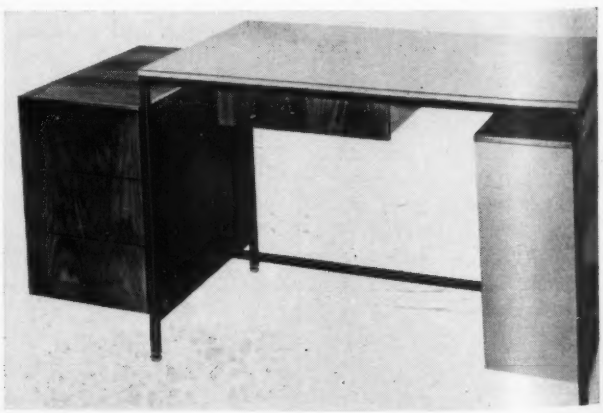
New "super" towel has been developed to meet demand for a disposable tissue towel of more adequate size for hospital and medical use. In white, size 25"x 14", the towel will be bulk-packed 500 to the case. Kimberly-Clark Corp.

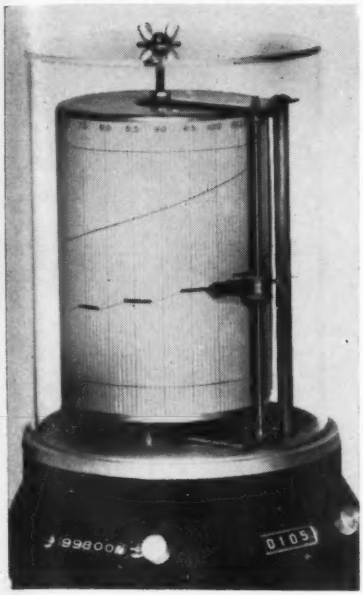
432A. Human skeleton model

New human skeleton model, 12" high, is available in articulated, unbreakable, pliant plastic. Suspended on a hanger, has a non-tip base, and is easily removed for close study. Black background for clear visibility. Orthopedic Equipment Co.

433. Add-a-unit desk

Desk is suggested for use in hospital administrative offices, nurses' dormitories, patient lounges, and similar areas. Basic frame is available either as a free-standing or wall-hung unit in 36", 42" and 48" widths. Units which can be added are a 3-drawer pedestal, open-shelf single or double bookcases, and kneehole drawer. Over 300 possible combinations are available from basic components. Royal Metal Manufacturing Co.

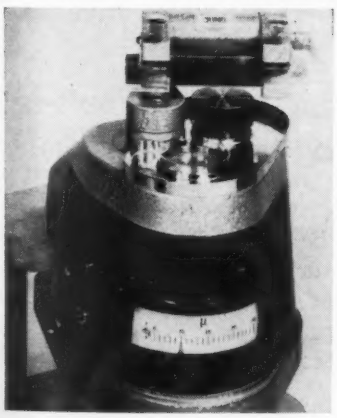




439. Efficiency recorder

Recorder chart shows the 'on' or productive time as well as the idle or 'down' time. Continuously recorded in percentage of time, hence readable for any length work period. During productive time, graphic line climbs upward at an angle. During idle time, line instantly becomes horizontal, broad, and conspicuous. Gorrell & Gorrell.

440. Quick-freeze microtome



New Universal Quick-Freeze Microtome 1200 has fully automatic object feed, accommodating from 2 to 40 microns in steps of 2 microns. Instant transition from frozen to paraffin work is achieved by a change of the object plate—no need to remove freezing chamber. Integral 2-way valve cools object as well as knife. William J. Hacker & Co.

441. X-ray screen

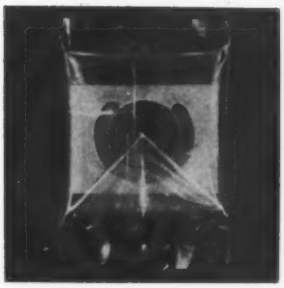
Flexible Par Speed x-ray intensifying screen has special protective coating over screen's luminescent surface which prevents damage from x-ray processing or photographic chemicals. Highly durable, screen may be used in standard cassettes. Du Pont Photo Products Department, E. I. du Pont de Nemours & Co.

442. Pocket microscope

Only slightly larger than a fountain pen, this pocket microscope has field of view of 2.8 mm., 2.4 mm., and 2.1 mm. Power is adjustable by sliding tube; settings are obtained by means of set screw at 20X, 40X, and 60X. Milled ring near lens provides focus, and chrome tip reflects light on the object. Edmund Scientific Co.

443. Vacutainer pilot tube

In new sterile specimen pilot tube with preservative, coagulated blood can be stored under refrigeration a minimum of 28 days manufacturer says. Can also be used as a serology tube, and in selected tissue culture studies. Becton, Dickinson & Co.



445. Urine collector

PUC-10-S, a sterile polyethylene bag, makes it possible to collect sterile urine specimens without catheterization. Can be used for both male, and female infants, and is self-sealing for safe transportation. Sterilon Corp.

446. New tape

Curve Line tapes has added six new patterns to its line of precision-slit, pressure-sensitive, printed tapes for charts and graphs. Width measurements guaranteed to plus or minus .002". Chart-Pak, Inc.

444. Pediatric stretcher

New, smaller stretcher incorporates a variety of optional accessories usually available only on larger units. Stretcher is adaptable to all pediatric needs, can also be used as an adjunct to recovery room service. Hausted Manufacturing Co.

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Only high steam temperatures can bring out these tell-tale marks on "Scotch" Hospital Autoclave Tape No. 222

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. . . WHERE RESEARCH IS THE KEY TO TOMORROW

FILMS, NEW LITERATURE

450. Research equipment

New catalog describes all Sanborn recording equipment, monitoring oscilloscopes, related equipment, and transducers. Of interest to biophysical researchers, medical teachers, and others concerned with measurement, recording, and study of physiological phenomena. Medical Division, Sanborn Co.

451. Teaching aids

Electronic equipment used in the classroom is described in illustrated booklet. Includes sound systems, speakers, projectors, recorders, radio and television sets, test equipment and special TV teaching systems. Radio Corporation of America.

452. OR static electricity

New brochure lists precautionary measures for dissipating static electricity in the operating room. Included is information on conductive floor maintenance. Huntington Laboratories, Inc.

453. Infrared instruments

Beckman infrared spectrophotometers for routine laboratory qualitative and quantitative analyses are described in new brochure. Performance features of the Beckman Double-Beam IR-5 and Single-Beam IR-6 are detailed; listings given for complete line of liquid, gas, and solid sampling equipment. Beckman Scientific Instruments Division, Beckman Instruments, Inc.

454. Hospital accounting

Simplified accounting plans for hospitals are discussed in a new brochure which highlights patients' accounting; shows briefly how one accounting machine can also handle payroll, government reports, outpatient accounts and the general ledger. Burroughs Corp.

455. X-ray analysis

X-ray Analysis Theory and Instrumentation, new 12-page, illustrated booklet, covers basic difference between film diffraction, diffractometry and spectrography. Subjects include Bragg's law, diffractometer, wide range goniometer, electronic circuit panel, counting rate computer, spectograph assembly, scintillation, proportional and flow proportional detectors, Geiger tubes. Instruments Division, Philips Electronics, Inc.

456. New AMA films

The American Medical Association has announced release of the following new films: *Helping Hands for Julie,* produced in co-operation with E. R. Squibb & Co., describes a little girl's fight for life in a hospital emergency room.

The Man Who Didn't Walk, produced by William S. Merrell Co., in co-operation with AMA and the American Bar Association, has as its subject traumatic neurosis.

Esophageal Perforation in a Sword Swallower shows the surgical closing of the perforation; also demonstrates correct sword swallowing technic.

Two films were produced in Czechoslovakia. One illustrates the diagnosis, evaluation, and surgical treatment of intracranial aneurysms, the other describes the surgical technic for a lung operation.

457. Use of bandage

"Clinical Use of Gauztex" is 16-page booklet on bandaging procedures. Described in detail, with diagrams, are various uses of sterile, self-adhering bandage. Procedures for bandaging in orthopedics, surgery, neurosurgery, and podiatry are covered. Useful as reference work or in classroom. General Bandages, Inc.

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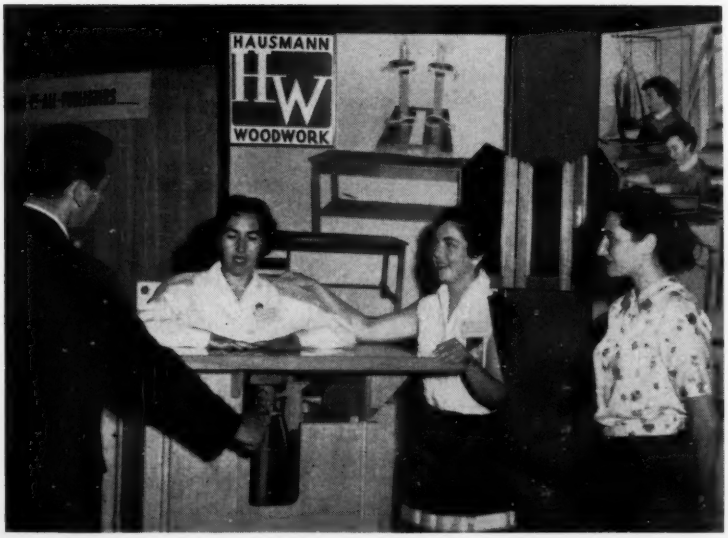
From the Conventions...

TOPICS' camera views exhibits at the 35th annual conference of the American Physical Therapy Association at Seattle, Wash., June 15-20.

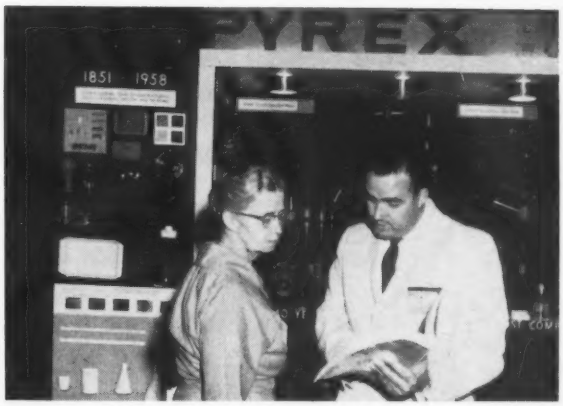
"Rehabaphone," devised to make telephoning possible for persons with little or no muscle power, is tested by Laura Sundquist (r.), Seattle, while Margaret Miller, Pocatello, Ida., looks on. Ted Becker, Seeger-Williams, Inc., explains that mechanism is operated by pressing, in any way, against the lever of a sensitive micro-switch. There is one switch for turning device on and off, another for dialing. Patient may activate mechanism by bulging out the cheek with the tongue. Gooseneck microphone, 18" long, adjusts to any position. C-460

Below: Axial resistance exercising unit, featured at the Bailey Manufacturing Co. exhibit in Seattle, is shown by Lee Thompson (r.) to Erika Reimer, Berkeley, Calif. Unit's upper extremity accessory group is said to cover wider range of shoulder, arm, and wrist exercises than was formerly possible with one unit. C-461



Werner Hausmann, W. R. Hausmann Woodwork, Inc., demonstrates to physical therapists stand-in table built for adults. With hydraulic system, table can easily be raised or lowered to adjust to a person of any height. Looking on (from left) are Borghild Klove, Cerebral Palsy Clinic, and Patricia Holland, Long Hospital, both at Indiana University Medical Center, Indianapolis, and Mrs. Werner Hausmann. C-462

TOPICS covers exhibits at the 26th annual convention of the American Society of Medical Technologists held in Milwaukee, June 15-20.



Right: Frank Sharpe, Corning Glass Laboratories, shows recently released catalog to Elizabeth Wiele, head laboratory technologist, Municipal Worthington (Minn.) Hospital. Exhibit featured Micro Ware, Needle Valve Ware, and new laboratory glassware. A section was devoted to glassware used by public health laboratories. C-463

New micro-chemistry centrifuge was exhibited by Clay-Adams, Inc. Lew Bell demonstrates the workings of the machine to Elizabeth Deane, head laboratory technologist at Burge Hospital, Springfeld, Mo. One adapter is double-ended and will accommodate several different glass or disposable plastic tubes; the other single adapter accommodates standard .5-ml. and 1-ml. tubes. A dial timer con[illegible] the time interval, and an automatic electric brake stops the centrifuge. The 115-volt Universal-type motor is wired for AC current. C-464

B. J. Blankenship explains Hyland Laboratories' new Ra-test to Jane Nightingale, chief medical technologist, St. Paul's Hospital, Dallas, Tex. A rapid-slide test for the rheumatoid factor developed by persons with rheumatoid arthritis, the new item is in kit form, includes testing materials and divided glass slide. C-465

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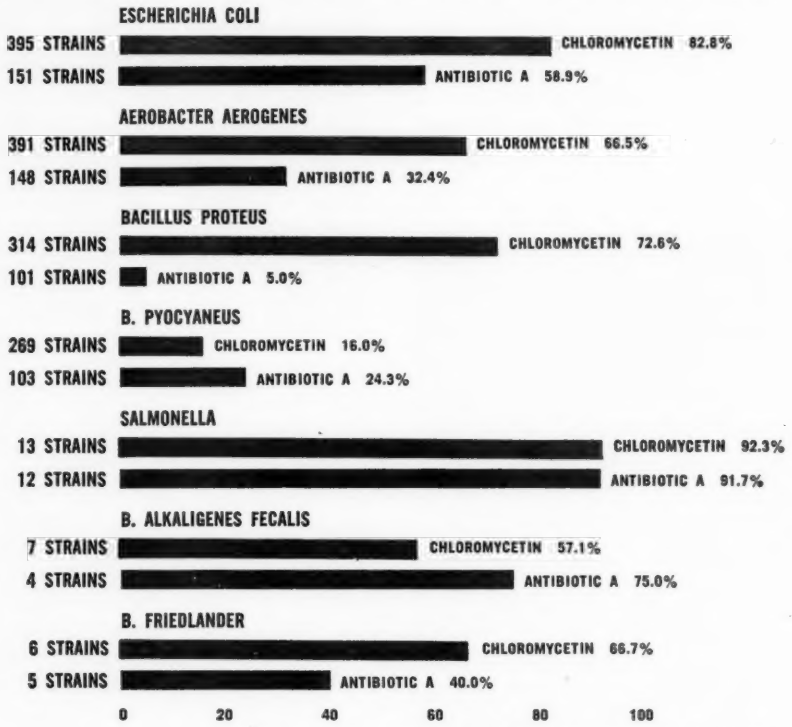

*Adapted from Schneierson, S. S.: *J. Mt. Sinai Hosp.* 25:52 (Jan.-Feb.) 1958.

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MEDICAMENTA VERA

The Pharmacy

Treating a Stress Reaction in Nursing Students

By Martin Markowitz, M.D.*

• Under the stress of a new job or a new environment, people often develop a state of lassitude and weakness that is not always fully explainable on a functional basis. True, at first the symptoms may be purely emotional ones; but if the stress and the person's reaction to it persist, usually physical manifestations develop. The appetite fails, food habits become irregular, and nutrition suffers in one way or another.

The following study shows the effect of a nutritional supplement and hematinic in counteracting this condition.

Nowhere is such a stress reaction more evident than among student nurses during their initial year of training. In most cases, these young women are away from their home environment for the first time. Their course of study is intensive. At the same time, they are receiving their first exposure to working with the sick, quite an ordeal for any young woman. It is no wonder that most of them suffer some degree of physical and emotional letdown.

The physical reaction may be reflected in various ways. Upon joining the staff of physicians at the Prospect Heights Hospital School of Nursing, I began reviewing the nursing students' medical records for the previous year. Of 18 students, 12, or 66 percent, showed a fall in hemoglobin levels varying from 3 to 15 grams percent, after being in the school for about six months.

The health of these young women is well supervised. Prior to admission, they receive a complete physical examination which includes a chest x-ray, urinalysis, complete blood count, serology studies, and any other special examination that may be warranted.

During their training, daily clinics are held to treat even the most minor illnesses. The students are examined several times yearly, and also before and after their affiliation assignments.

As far the students' diet is concerned, the food served them is adequate in every way and it is tastefully prepared. The diet is surely more scientifically balanced than the one they receive at home, although it is recognized that there is no cooking like Mother's. However, the diet offered to these students is more than adequate in flavor and appearance as well as in health-building qualities.

Despite all this care and supervision, the indisputable fact remained that 12 students experienced a definite drop in hemoglo-

(*Continued on next page*)

Hemoglobin determinations in student nurses before and after six months' supplemental therapy with a hematinic. In all but one of the 23 students, maintenance of the original hemoglobin level, or a rise in the level, occurred.

	Hemoglobin level in grams percent		
Student	Before Therapy	After Therapy	Change
1	80.8	77.8	—3.0
2	77.8	77.8	—0
3	74.8	77.8	+3.0
4	74.8	74.8	—0
5	83.8	89.8	+6.0
6	77.8	83.8	+6.0
7	80.8	80.8	—0
8	83.8	89.8	+6.0
9	80.8	86.8	+6.0
10	83.8	83.8	—0
11	74.8	83.8	+9.0
12	80.8	89.8	+9.0
13	80.8	89.8	+9.0
14	78.8	78.8	—0
15	83.8	83.8	—0
16	80.8	86.8	+6.0
17	80.8	80.8	—0
18	77.8	80.8	+3.0
19	74.8	77.8	+3.0
20	77.8	77.8	—0
21	77.8	77.8	—0
22	74.8	80.8	+6.0
23	71.8	77.8	+6.0

* Attending physician, Prospect Heights Hospital, Brooklyn, N.Y.

bin. We interpreted this drop as being their reaction to the mental and physical stress of their introduction to the nursing routine.

It was decided to treat the next first-year class of nursing students with a hematinic, one containing additional nutritional factors, to determine if a decline in hemoglobin level could be prevented. With the co-operation of Mrs. Pianelli, the director of nursing education, a program of treatment in a group of 23 students was begun.

First the hemoglobin level was determined in each student. Then each one began taking one capsule of a supplemented hematinic† twice daily. The program continued for six months. At the end of this period, a repeat hemoglobin determination was recorded for every member of the group.

It was found that none of the students showed a significant drop in hemoglobin level. In fact only one student showed any lowering at all, and the drop in this case was only 3 grams percent.

Thirteen of the 23 students demonstrated a rise in hemoglobin level, ranging from 3 to 9 grams percent (see table, page 85). The other nine students in the group maintained their original levels.

Thus it can be seen that an increase in the hemoglobin level occurred in about 56 percent of the group studied, and the original level was maintained in about 39 percent.

The findings in this study were not considered to be merely a coincidence. Further, this objective change in hemoglobin level was observed in a well-administered nursing school. It is not unlikely that a similar alteration might be found in other student groups exposed to the same type of emotional and physical stress.

The therapy itself was well-tolerated. The prevention of a diminution in hemoglobin is a relatively simple procedure, and such prevention is most practical.

†Fergon Plus, supplied through the courtesy of the medical research department, Winthrop Laboratories, New York City. The formulation used contained 3 mcg. vitamin B_{12}; 1.5 mg. folic acid; .12 Gm. liver fraction 2, .2 Gm. ferrous gluconate; .12 Gm. gastric mucosa; 50 mg. ascorbic acid.

prescription pad

For Migraine Headache

Migral, introduced by Burroughs Wellcome & Co., Inc., for treatment of migraine and other vascular headaches, includes anti-emetic for control of nausea and vomiting arising from migraine attacks and from ergotamine administration.

Each Migral tablet contains 1 mg. of ergotamine tartrate, 25 mg. of Marezine, brand of cyclizine hydrochloride, and 50 mg. of caffeine. Sugar-coated tablets are supplied in bottles of 20 and 100.

Contact Laxative

Dulcolax, manufactured by Geigy Pharmaceuticals, is a contact laxative for treatment of constipation. It acts directly on colonic mucosa, does not produce systemic effects.

A new synthetic compound, bis-(p-acetoxyphenyl) - 2 - pyridylmethane, Dulcolax is virtually insoluble in intestinal juices.

Dulcolax is available in yellow, enteric-coated tablets of 5 mg., and in suppositories of 10 mg.

For Biliary Disorders

Probilagol is new liquid compound designed to initiate physiologic action of the gallbladder.

Manufactured by The Purdue Frederick Co., Probilagol contains, in each teaspoonful (5 ml.), 4.5 Gm. of D-Glucitol, and 1 mg. of homatropine methylbromide. It is supplied in bottles of six and 12 fluid ounces.

Muscle Relaxant

Sinaxar, developed by Armour Laboratories, is a long-acting muscle relaxant for relief of pain, stiffness, spasm.

The drug is a new synthetic chemical, 2-phenyl, 2-hydroxy-ethyl-carbamate. Sinaxar tablets, 200 mg. each, are supplied in bottles of 50.

Bactericidal Antibiotic

Kantrex, Bristol Laboratories' brand of kanamycin sulfate, is a broad spectrum bactericidal antibiotic for treatment of a variety of pathogenic organisms including Gram negative and Gram positive bacteria and staphylococci resistant to other antibiotics.

The drug is recommended by manufacturer for treatment of infections of urinary and respiratory tracts and for presurgical intestinal antisepsis since little absorption from the gut takes place when drug is given orally. Kantrex has not shown cross-resistance with any other major antibiotic.

Kantrex is available for intramuscular administration in vials of 500 mg., as 2 cc. of clear solution, and in vials of 1 mg., as 3 cc. of solution. For oral administration, it is supplied in 500-mg. capsules, in bottles of 20 and 100.

New Dosage, Forms

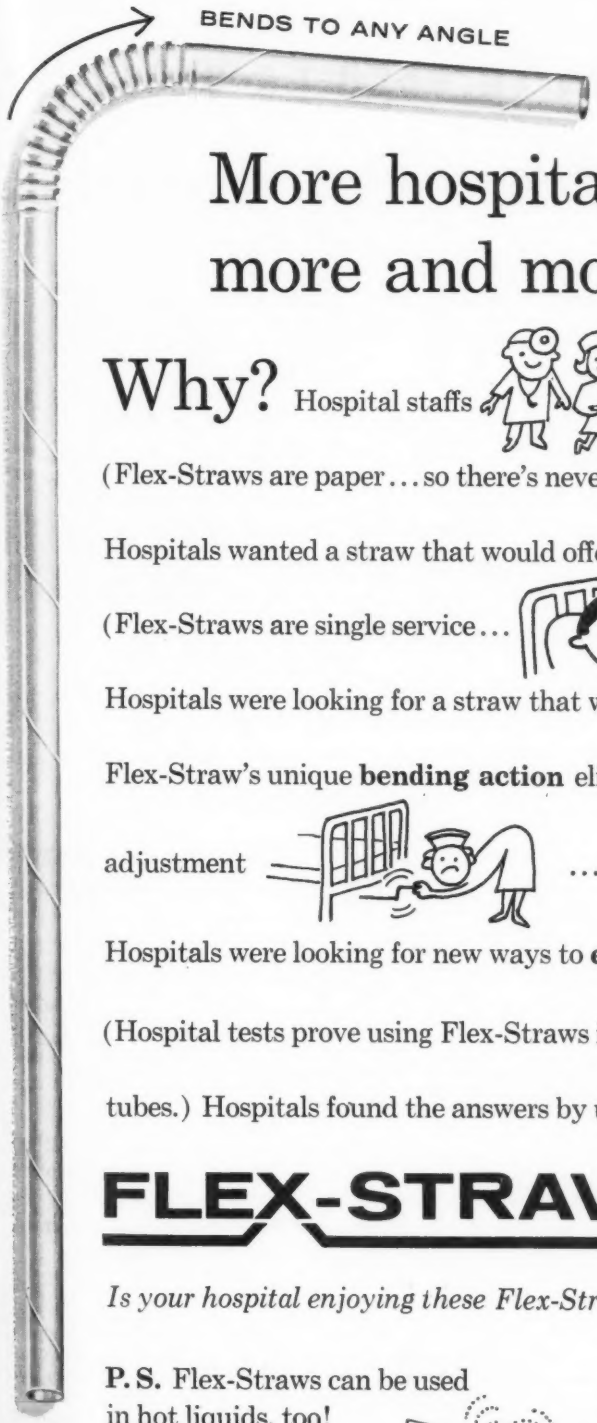
Fleet Enema Disposable Unit is now available in pediatric size of 2¼ fluid ounces, one-half the adult size. Each 100 cc. contains 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate, in unit with prelubricated rectal tube attached to polyethylene bottle. Available in single units from C. B. Fleet Co., Inc.

* * *

Availability of Neohydrin with Vitamins, for management of edema, has been announced by Lakeside Laboratories, Inc. Each tablet contains 18.3 mg. Neohydrin (chlormerodrin); .667 mg. thiamine hydrochloride; .667 mg. riboflavin; 6.667 mg. nicotinamide; .667 mg. pyridoxine hydrochloride; 1.667 mg. calcium pantothenate; and 25 mg. ascorbic acid. Tablets are supplied in bottles of 50.

* * *

Wallace Laboratories has introduced Meprospan, a prolonged release form of meprobamate, for relief of anxiety and tension states and muscle spasm. Each yellow and-white Meprospan capsule contains 200 mg. meprobamate in coated pellets which release the drug over a 10- to 12-hour period. Capsules are packaged in bottles of 30.



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THE LAB

Growth Through Co-operation Is Theme of 26th ASMT Convention

Elizabeth O'Connor (l.), MT (ASCP), Evanston, Ill., took office as president of the American Society of Medical Technologists at the Milwaukee convention. Miss O'Connor is chief medical technologist for Illinois Bell Telephone Co., Chicago.

Leonard A. Scheele, M.D. (r.), chairman, Commission on Health Careers, National Health Council, and president, Warner-Chilcott Laboratories, gave the keynote address at the opening of the convention. Dr. Scheele was formerly surgeon general, U.S. Public Health Service.

•Over 1,000 men and women, members of the American Society of Medical Technologists, gathered for the society's 26th annual meeting, held in Milwaukee, June 15-20. Among the significant announcements at the meeting:

- Affiliation of ASMT with the American Association for the Advancement of Science.
- New professional ratings, upgrading medical technologists within U.S. Civil Service.
- Postgraduate grant from the laboratory supply division, Warner-Chilcott Laboratories, to be administered by ASMT. Available to ASMT members who have worked for the past three years in a laboratory associated with an approved school, or who are already teaching in such a school, it may be used to begin or continue studies towards a master of science degree in one of the medical sciences.

In line with the ASMT recruitment program, the society's scholarship committee reported that 31 funds, offering more than $10,000 a year in scholarships and loans to students in the medical technology field, are currently available.

In 1955, only four state societies were known to be actively engaged in scholarship activities. This year, 42 state groups have active committees, or have appointed a member as a scholarship contact.

Seventeen states sponsor scholarships or loans, and eight others are organizing funds this year; four maintain lists of general scholarships within their state for which student technologists are eligible.

Following are abstracts from the keynote address, medical and technological reports:

Dr. Scheele Terms 1958 'Year of the Turning Point'

Cites Efforts to Meet Manpower Challenge

In answer to the question "What is a profession?" Dr. Vannevar Bush recently noted: "The primary characteristic is to minister to people—to serve them with dignity, devotion, and skill."

According to that definition, there is no question that the place of medical technology is alongside that of its sister professions in the

(Continued on page 90)

Esther F. Freier (l.), and Verna Rausch (center), both of the University of Minnesota, Minneapolis, were presented with the Hillowitz award of $250 for best original research in the field of medical technology. Miss Freier is instructor in medical technology and hospital chemist, University of Minnesota Hospital; Miss Rausch is assistant professor of medical technology. Bess Ehmann (r.), Wampole Laboratories, presented the award.

Ruth Heineman, president-elect of ASMT and co-chairman of its Civil Service-Armed Services Committee, talks with Dr. C. Mansel Keene, chief, Standards Division, U.S. Civil Service, who announced new professional ratings series which will upgrade medical technologists.

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Left: Henrietta M. Lyle, chief technologist, Washington County Hospital, Hagerstown, Md., received the annual Corning Award, naming her the outstanding medical line technologist in the U.S., at the ASMT convention. She received $500 and an inscribed Steuben glass bowl. Judges of the award, sponsored by the Corning Glass Works, were (l. to r., above): John Hinman, M.D., assistant secretary, Council on Medical Education and Hospitals, American Medical Association; Doris S. Whitney, ASMT public relations committee; George Stevenson, pathologist, St. Joseph's Hospital, Chicago; and Jane A. Farrant, Public Information and Education Division, American Hospital Association.

THE LAB

(Continued from page 88)

health field. Many encouraging developments can be seen just within the past 12 months:

—A resolution has been passed by the American Society of Clinical Pathologists confirming the technician's professional status.

—Moves have been made toward an equally significant advance in recognition by the federal Civil Service Commission.

—Joint consideration has been given by ASMT and the American Medical Association, to increasing MT educational requirements to three years of college before the final year of hospital study.

In addition, ASMT has taken leadership in opening the door to employment for the physically handicapped, as well as young people; you are a good deal more realistic than some groups in adjusting to the womanpower revolution.

Common points of interest of the Commission on Health Careers and ASMT concern the need for better-trained, better-paid medical technologists. The health careers project sponsored by the commission is underpinning recruitment efforts of ASMT in various ways, including these:

1. *Use of health career materials.* More than 100,000 copies of the career guide book have been distributed.

2. *National agency participation.* Professional societies, voluntary and governmental agencies, and other organizations, including the Woman's Auxiliary of the American Medical Association, have adopted health careers as a national project.

3. *State and community health career committees.* More than 200 state and community groups have initiated and are carrying on organized health career programs. The medical technology field is represented in 39 of the 89 committees, with participation by 70 state and local groups.

4. *Local health careers information.* A growing crop of full-fledged local health career publications are presenting information in addition to that in the press and in school papers.

5. *Future plans.* Slated for special emphasis in coming months: Workshop conferences with professional associations and national health agencies on the improvement of recruitment material and methods; ways and means of interpreting health careers to parents; supplementary service to the schools to provide material for classroom as well as counseling use; continuation of efforts to promote recognition of the health field as a major area of career opportunity for science-minded young people.

Weighing strengths against problems and pressures, we have as much cause for confidence as for concern. Not only in medical technology, but everywhere throughout the health field, there are signs that mark 1958 as a-year-with-a-turning point. The health professions will surmount the manpower challenge. —*Leonard A. Scheele, M.D.*, chairman, Commission on Health Careers, National Health Council, Washington, D.C.

Small Lab Can Handle Bacteriologic Diagnosis

Larger Scope of Work Possible Than Generally Recognized

Many technologists, having received their training in large institutions, make no attempt to do determinative bacteriologic procedures on a small scale. Yet a great deal can be accomplished with limited equipment.

Most laboratories or offices are equipped with a refrigerator, Bunsen burner, centrifuge, and possibly an autoclave. In lieu of the latter, an ordinary pressure cooker may be used. A staining rack is easily improvised. As a candle jar, any container which can be tightly closed, such as a coffee can, will serve.

Loops, needles, test tubes and Petri dishes must be obtained. Petri plate handling can be obviated by the use of sterile disposable plastic plates.

This equipment, together with dehydrated or prepared media and stains, will be adequate for work with culture media, stains and reagents, for preparation and plating of specimens, and for identification procedures and sensitivity testing.

In most cases, identification must be on a presumptive basis, and this fact should be submitted in the report to the physician so that he may interpret the correlation between culture reports and clinical findings in the proper light. Frequent con-

sultation with the attending physician is of considerable benefit. Knowing what pathogens are suspected, the technologist can concentrate his efforts on specific procedures.—*Jo Anne F. Holzman, S.B., MT (ASCP)*, University of Texas Medical Branch.

Some Radioisotopes Seek Bone Tissue

Slow Bone Metabolism Factor in Cancer

Certain elements, when administered, go to the bone tissue where they are avidly held for a long period. Such elements, known as bone-seekers, have a very slow turnover in the bone metabolism.

Duration of the energy from these elements in the body has a tremendous range. Iodine requires eight days to reduce its activity by one-half; Strontium 90 (now present in our environment) requires 28 years to reduce its potency by one-half. It must give us thought for protective measures, and also allay fears so prominent in the public mind regarding fall-out and similar hazards, to realize that doses for experimental cancer research are thousands of times more potent than elements currently in the atmosphere.

The presence of radioactive elements in the body may alter the chemical and enzyme systems with long-lasting results.

A period of excessive repair in all cells follows their exposure to radiation. Because of bone's slow metabolism, it is six to eight months before repair begins and an area of new bone forms.

Even then, in many cases, the cells are immature and do not form hematolystically; that is, bone is formed lacking marrow, and thus, cure is not indicated. In Strontium 90 therapy, mucous membrane may also become cancerous because of its proximity to bone.—*Joseph F. Kuzma, M.D.*, professor and director, Department of Pathology, Marquette University School of Medicine.

Radioisotopes Useful in Medicine But Use Can Be Hazardous

Radioisotopes are useful in diagnostic procedures because, in the amount used, they do not disturb the physiological picture of the patient. Extremely small amounts of the radioactive chemical element or compound can be detected quantitatively *in vivo* and *in vitro*.

These compounds are useful in therapeutic procedures because they constitute sources of radiation which can be used internally or externally, and because the radiation can be localized, physically or metabolically.

Problems involve potential hazard to the patient, to the technician, and to public domain. In a clinical radioisotope laboratory, harm may result from improper use of, or inadequate, protection measures. Even extremely small amounts of radioactive material taken into the body must be considered harmful, and this material should be handled in the laboratory in a manner approximating radiochemical asepsis.

Technicians must know where, when, and how hazards exist, and what to do to eliminate, avoid, or minimize them. Technicians must keep at high level their use of instrumentation, to evaluate any radiation situation; their apparatus so that it may be handled with safety; and their technic for minimizing exposure.—*Frank Karioris, M.S.*, assistant professor of physics, and consultant to Department of Isotopes, Marquette University School of Medicine.

Jean E. Dinwoodie, surgical researcher, Tufts University School of Medicine, Boston, is absorbed by a factual discussion of routine blood pH determinations given by S. Raymond Gambino, M.D., assistant pathologist, St. Luke's Hospital, Milwaukee.

Technology Routines Used In Autopsy Service

Technologist Vital In Smaller Hospitals

The place of the medical technologist in the autopsy room of smaller hospitals is important because she is concerned with all phases of the routine.

Procedure is the same as on a patient, with no sacrifice of accuracy, no less sterile technic. Tests include smear and culture of inflammatory material anywhere in the body; bone marrow analysis; sen-

(Continued on next page)

Time out for fun! Medical technologists relax from busy convention schedule with a boat ride on Lake Michigan. They were guests on the Hydrion II, Coleman Instruments' 42-foot cruiser. In the front row (l. to r.) are: Patricia Sallas, Nancy Bailey, Elizabeth O'Connor, incoming ASMT president, and Doris Whitney, publicity director. Back row (l. to r.): Harry Simonson, Bernard Friedman, Jean Schlafeman, C. H. Humes, Mrs. Louise Simonson, Skipper Dave Keefer, and C. A. Rossiter.

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sitivity tests; blood and spinal fluid tests. Sections of the brain and spinal column are frozen and sent to larger laboratories for analyses.

In medical-legal autopsies, blood stains are typed to determine if they match the victim's. In cases of human incineration, carbon monoxide in the blood is measured. In the presence of poison, one kidney, a large fragment of the liver, gastric contents, bone fragments, and specimens of blood and urine are refrigerated, with no preservative added, for further study.—*Sister Mary Margaret Henkes, MT (ASCP)*, St. Joseph's Hospital, Beaver Dam, Wis.

Cites Role of Lab In Antibiotic Therapy

New Specialists Needed As Hematherapeutists

Before 1900, "antibiotic" medical care consisted of vaccination. In 1956, over 2,500,000 pounds of antibiotics were manufactured; one-quarter of this amount was penicillin, the remainder was divided among 17 other products.

We must have new medical specialists—men and women trained as hematherapeutists.

Such specialists would analyze new hematherapeutic agents from drug firms; advise physicians of the patient's blood level and determine if the amount of antibiotic administered is adequate to build a satisfactory level; inform the physician of bactericidal activity in the patient since no favorable response can be anticipated unless the organism is treated with killing doses in the early stages; handle susceptibility tests, by dilution or infusion, to determine whether microorganisms are mildly resistant or resistant to a particular drug.

In using discs, which vary among manufacturers, the medical technologist can assist by using organisms of known sensitivity on the disc, and having a close running control on the tests.

The laboratory director is failing in his professional duties if he is unaware of failures in technic, or does not correctly evaluate the lab's contribution to the attending physician.—*Gerald M. Needham, Ph.D.*, assistant professor in bacteriology, Mayo Foundation, University of Minnesota, Minneapolis.

Cardiac Catheterization Is Valuable Diagnostic Tool

The Tool and the Technic Used To Determine Heart Disease

Cardiac catheterization includes many tests which use the heart catheter as a basic tool. The heart catheter, a slender, pliable, hollow tube about one yard long, is inserted into an arm vein and, with the aid of the fluoroscope, is guided up the arm vein and into the chest.

The top of the catheter may be placed directly within the heart chambers, allowing direct pressure measurement, the sampling of blood, the injection of various medications, dyes, and radiopaque material, and the recording of an intracardiac electrocardiogram.

By the use of these technics, an exact diagnosis may be made in patients with congenital or acquired heart disease. This information is a prerequisite to surgical repair of these abnormalities. Also, these technics are teaching us more and more about how the normal heart responds to various stimuli and medications. — *John H. Huston, M.D.*, assistant professor and director, Cardiopulmonary Laboratory, Marquette University School of Medicine, Milwaukee.

Chicago Supervisor Is First U.S. Blood Bank Specialist

Shirley Busch, on passing an examination in June, became the first blood bank technologist in the U.S. to be certified as a blood bank specialist by the Registry of Medical Technologists of the American Society of Clinical Pathologists. Miss Busch's title is "Specialist B.B.I."

Miss Busch, who wrote her thesis on the role of antibody screening as a safeguard for selection of blood for transfusions, has been supervisor of Chicago's Mount Sinai Hospital blood bank since 1951.

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Pediatrics

Familiar Toys Aid In Pediatric Anesthesia

By George M. Collins, C.R.N.A.*

• The successful anesthetist satisfies the patient, the surgeon, and himself. Anesthetics must be tailored to the physiologic status of the patient, the requirements of the proposed surgical operation, and the convenience of the surgeon. The anesthetist must be both skillful and tactful in meeting each need, and must make all necessary preparations to accomplish his tasks without hesitation or delay.

The anesthesia department at St. Francis Hospital, La Crosse, Wis., for the last five years has been considering methods for giving more satisfactory service to the patients it serves. The study began with the pediatric patients because it was quite obvious that the needs of these patients were the most critical.

Because a child cannot understand completely the circumstances that have confined him to the hospital, more effort must be made to relieve the stress of his situation. The greatest of all the disturbances his emotions will suffer is, of course, the separation from his parents. Every effort must be made by the nursing staff to supply the love and trust and comfort that he received from his parents. The anesthetist likewise must give him comfort, so that he can go through surgery without added onslaught to his emotional state.

During the preoperative visit the anesthetist must evaluate the child for the requirements of the operation and for the anesthetic. Success in anesthetic induction and maintenance depends, for the most part, upon the patient's emotional state.

In adults, preoperative sedation is achieved by the administration of depressing drugs, which depress not only the patient's emotions but also his vital functions. In children, however, vital functions are most delicate and must be controlled by safer means.

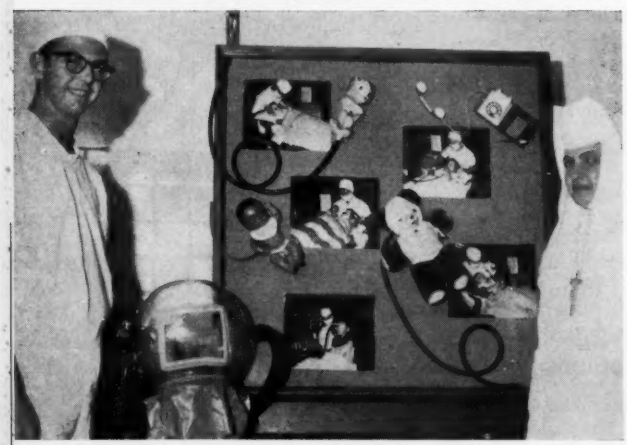
Seven-year-old tries on space helmet before anesthetic is started. Helping him are Signe Gulbrandsen (l.), Viroqua, Wis., and Judith Bruha, La Crosse, Wis., anesthesiology students at St. Francis.

A demonstration of affection by the persons serving the child is a more satisfactory means of soothing his emotions. Establishing in the child a feeling of trust will take time. The anesthetist must be genuine in his concern, for the child can detect insincerity without hesitation. The time taken to win the child's trust will be well spent. It will contribute to the anesthetist's success and the surgeon's ease of operation. Lack of control of the child's emotions could lead to a disastrous result.

Use of the preoperative visit to establish rapport and to gain the child's confidence brought a realization of the great part that toys play in a child's emotional life. The toys are accepted as real persons and exert real influences upon the child. The child may mutilate a toy when he is in a revengeful mood and smother it with love when he is in an affectionate mood. The toy is a necessary part of a child's life—a friend who will offer understanding and a companion to share the child's sufferings.

These all-important toys often are not attractive, nor need they be new or in good condition. Armless dolls or legless animals are equal candidates for the important place in the child's life. Their importance is greatly increased when the child has been hospitalized and removed from his parents' care.

Patrick Baker, Greenville, Pa., and Sister Mary Damian, Chicago, both students at the St. Francis Hospital School of Anesthesia, show display of toys fitted for anesthesia administration.



*Mr. Collins is assistant director, School of Anesthesiology, St. Francis Hospital, La Crosse, Wis.

We decided to utilize toys in preparing children for anesthesia. We chose five toys which seem to be preferred most often in the pediatric wards. These toys were fitted with tubing that could be connected to an anesthetic source. In the panda bear and the baby doll, for instance, a conductive rubber tube was inserted into the lower back of the toy, and was then brought up through the body to the toy's mouth and sewed into place. The other end of the tube was connected to a gas machine.

As the child is placed on the operating table, he is asked to hold the toy near his face. The gas on the machine is turned on and allowed to flow through the toy. Because the anesthetic gases used in this technic are heavier than air, the gases flow down over the patient's face. The child inhales the anesthetic without fear or emotional excitement. Induction of anesthesia is accomplished in a very short time.

The space helmet is the toy preferred mostly by boys seven and eight years of age. The inhaling tubing from a gas machine is connected to the opening in the sides of the helmet. The child is allowed to place the helmet over his head unaided. He is told to count as he drifts off into space. The counting causes him to focus his attention on the procedure at hand, and thus overcomes the possibility of any fear the closed helmet might cause. Induction of anesthesia takes about three minutes.

Our intention in using these toys is not to steal the child off into anesthesia, but rather to offer him a companion for the adventure of anesthesia. The child is told exactly what will happen. The mechanism of the toys is explained to him. Every detail of the procedure is told to him before anything is started.

It is fear of the unknown that upsets the patient who is to be reduced to unconsciousness. When the child is told the function of these toys, he is very enthusiastic. He is delighted with the idea that a toy with which he is so familiar can administer an anesthesia. He thus gains the needed assurance that he will be in familiar and safe company.

It takes time to use these technics, but it is a small price for such a great return. A child is, of course, emotionally upset in an uncertain situation. Wise conduct of the hospital personnel can relieve his fears.

A child is not by nature unapproachable or uncooperative. If he is bereft of love and comfort, it is understandable that he might be unsocial. Sincere concern for his welfare and an assurance of love and protection will win the co-operation of the most disturbed child. A soothing voice and gentle treatment prove to the child that the anesthetist's concern for him is genuine. This conduct, coupled with the use of toys to induce anesthesia, will bring a happy smile to the face of every child.

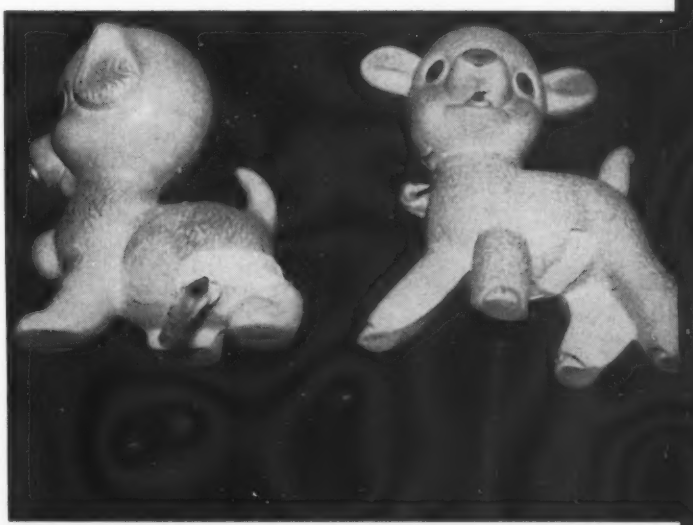
Toy Dog Is Anesthetic Aid At Boston Hospital

"Perky the Pup," an appealing little rubber toy, is used as an aid to pediatric anesthesia at Boston Floating Hospital, the pediatric unit of the New England Medical Center.

When the child holds Perky up to his face and squeezes it, he gets a whiff of the anesthetic, because the animal is connected with the rubber tubing to the gas machine.

Perky, developed by the anesthesia department, has been used successfully for five or six years to administer an estimated 4,000-5,000 anesthesias.

Illustrations on this page are from Chapter IV of a new textbook, *Pediatric Surgery* (New York: Appleton-Century-Crofts, Inc., 1958), by Orvar Swenson, M.D., professor of pediatric surgery, Tufts University School of Medicine. They are reprinted here through the courtesy of the publisher and the author.



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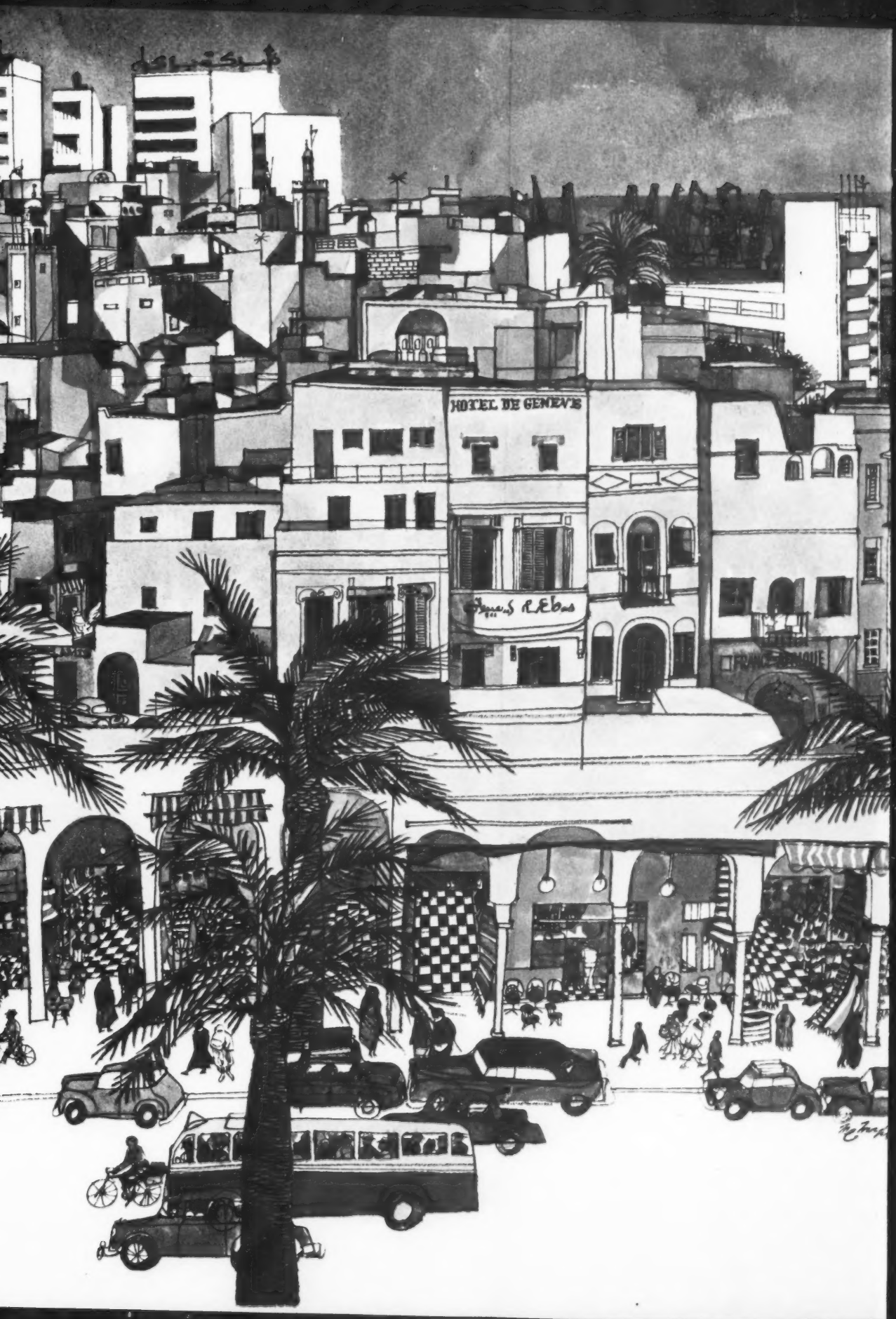
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Infant Feeding Practices in Hospital Maternity Nurseries*

A Survey of 1,904 Hospitals Involving 2,225,000 Newborn Infants

By Herman F. Meyer, M.D.†

• The varied practices in the routine feeding of infants in newborn nurseries in the United States are important to record as historic and scientific evidence of the customs of our times. This survey concerns some of the more important of these practices as they were applied in 1956 to 2,244,667 infants in 1,904 hospitals in the United States.

METHODS

A questionnaire containing 21 interrogations was submitted to the nursery supervisors of the 2,981 hospitals having birth rates of 300 infants or more in 1955.[1] The return of 63.9 percent of these questionnaires implies considerable enthusiasm and interest among supervisory personnel of maternity nurseries. Many pertinent comments were made and varied opinions relative to these procedures were volunteered.

A unique feature of the report is that the results are presented not only in terms of *hospitals*, but also in *numbers of infants* involved. A survey reported in terms of practices in hospitals without reference to number of infants would not be as comprehensive as one in which results are presented in terms of the number of infants studied. If only hospitals are rated, then one institution with 300 births per year would be weighed with the same value as one with 4,000 or more births annually.

Tables I and II in the article, not reprinted here, summarize geographic distribution of hospitals and numbers of infant subjects included in the survey.

Because more infants in American hospitals are artificially fed than breast-fed at the present time, this poll concerns itself in large measure with the kinds of milks used in maternity nurseries. Milk mixtures may be prescribed individually or specifically for each infant on an individual basis or there may be one mixture used for all infants in the nursery. The present study is concerned with this latter preparation, known generally as a "house formula." Other related data recorded are under the following categories: the authority within the hospital by which the specific formula is designated and the length of time the formula has been in use; the habit of changing from the specified house formula to another mixture; the age in hours when feeding is begun post-natally; the ages at which infants leave the hospital; the practice of manufacturers supplying gratis the constituents of the house formula.

*Reprinted with permission from *Pediatrics*, 21:288—96 (February, 1958).

†Children's Memorial Hospital, and Department of Pediatrics, Northwestern University Medical School, Chicago.

RESULTS OF SURVEY

House Formula

Of the 1,904 hospitals reporting on the questionnaire, 1,564 (82.1 percent) used a house formula, and the formula had remained unchanged for more than 12 months in 87.7 percent of these nurseries (Tables III and IV). Apparently the usefulness of such a formula has been commonly accepted.

The specification of the particular milk mixture to be used in any maternity nursery is not ordinarily left to chance as is sometimes inferred. It was found (Table V, page 98) that in 39.3 percent of the hospitals reporting on this question, a pediatrician in charge of the nursery made the selection while in 37.9 percent a committee of physicians were the authority. In 89.4 percent of hospitals the house formula was selected by a physician or physicians and in 8.2 percent it was selected by the superintendent of the hospital or the nursery or obstetric supervisor, and/or a representative of the purchasing department of the institution.

(Continued on next page)

Table III

Number of Nurseries in Survey Employing House Formulas

	Hospitals Reporting	Percent of Total	Infants Included[1]	Percent of Total
Have house formula	1,564	82.1	1,927,443	85.8
Do not have house formula	340	17.9	317,224	14.2
	1,904		2,244,667	

Table IV

Length of Time Formula in Use

	Hospitals Reporting	Percent of Total	Infants Included[1]	Percent of Total
Less than 12 months	161	10.3	173,005	9.0
12 months or more	1,372	87.7	1,711,812	88.8
Unknown	31	2.0	42,626	2.2
	1,564		1,927,443	

It is natural to assume that parents of infants born in a hospital may presume that the house formula must be the "best" food for their infant if it is endorsed by *their* hospital for *their* baby. Certain manufacturers of infant foods are aware of this subtle influence. Thus in the promotional program of these companies, it has become customary to supply hospital nurseries with their respective milk mixtures and sugars free of charge. In answer to this query, 817 hospitals reported that milk products used in their house formulas were received free of charge, and 921 hospitals reported receiving carbohydrate additives free.

An unusual situation obtains when the statistics of the armed forces' nurseries are observed. Of the 99 military installation hospitals (107,013 infants) reporting, 73 percent (69,000 infants) used a prepared milk mixture as the house formula, as compared with 37.4 percent of civilian-administered hospitals (574,895 infants). Of these 99 military hospitals, 93 percent reported receiving these products free from the manufacturers. It is not known how many of the babies born in military installation hospitals continued to receive the same formula after discharge from the hospital but apparently the feeding of about 15 percent of infants in this survey was changed to evaporated milk at the time of discharge from the hospital.

Table V

Authority for Designation of House Formula

	Hospitals Reporting	Percent of Total	Infants[1] Included	Percent of Total
Pediatrician in Charge	614	39.3	865,003	44.0
Physician in Charge	96	6.1	56,532	2.9
Committee of Physicians	593	37.9	749,462	38.9
Obstetrician in Charge, Maternity	95	6.1	80,392	4.2
Hospital Administration	129	8.2	138,006	7.1
Unknown	37	2.4	38,048	2.0
	1,564	100.0	1,927,443	

In Table VI (page 100) data are presented concerning 1,564 hospitals (1,927,443 infants) which reported the use of house formulas. The data in this table are divided into the categories of commonly used milk mixtures: diluted pasteurized milk with added carbohydrate; diluted evaporated milk with and without added carbohydrate; skimmed milk, liquid or dry; the prepared milk foods, liquid or dry; and 1 per cent of others, which include solutions of glucose or of other carbohydrates or protein. In studying the various practices in this category, no pattern or correlation can be distinguished as to states or geographic divisions. Only the over-all picture as summarized in Tables VII and VIII (page 101) can be identified.

Carbohydrate Modifiers and Additives

The need for the addition of carbohydrate to milk in preparation of infant formulas remains one of the minor controversies in infant nutrition. The reader is referred to other sources[4, 5] for a discussion of the reasons for the addition of carbohydrates to milk for the feeding of infants. As may be seen in the summary (Table VII), evaporated milk without added carbohydrate was used as house formula in 11.5 percent of the hospitals. One hospital of renown, with an average daily census of 120 infants and a birth rate of more than 3,500 per year, has consistently used a formula consisting of evaporated milk and water in equal amounts without additional carbohydrate for more than 20 years. Many nurseries of military installations during World War II found this same mixture convenient because of its simplicity,[6] and it has continued to be used since that time. It was presumed six or eight years ago by some of those interested in this subject that feeding of cow's milk without added carbohydrate would be a new fashion in infant feeding Except in limited geographic areas, no profound movement in this "new" phase of infant feeding is apparent.

Table VII

Composition* of House Formulas

	Hospitals Reporting	Percent of Total	Infants Included[1]	Percent of Total
Number with house formula	1,564	100.0	1,927,443	100.0
Diluted pasteurized milk and CHO	126	8.0	173,874	9.0
Diluted evaporated milk and CHO	999	63.9	1,313,556	68.1
Evaporated milk and water	181	11.5	227,605	11.8
(Total evaporated milk)	(1,180)	(75.4)	(1,541,171)	(79.9)
Pasteurized skimmed milk	23	1.5	39,432	2.0
Nonfat dry milk	8	0.5	9,603	0.5
(Total skimmed and nonfat milks)	(31)	(2.0)	(49,039)	(2.5)
Premodified prepared formulas,	585	37.4	643,895	33.4
Other	22	1.4	37,600	1.9

Other Practices in Newborn Nurseries

In this country the age at which food is first offered to the baby varies widely. As seen in Table IX (page 101), the greatest number of infants are first put to the breast at 12 hours of age, with extremes of four to 36 hours. Most infants are not offered artificial food until 24 hours of age. Apparently the age for initial feeding is selected arbitrarily. Some nurseries are dogmatic concerning the introduction of water, tea, or solutions of glucose or protein before milk mixtures may be given.

In Table X an interesting trend is evident as to the age of the newborn infant at the time of leaving the hospital, varying from two days to more than seven days, with the usual age (46 percent) of 5 days. It is not known whether the physical status of the baby, the mother's well being, or the crowded conditions of the obstetric ward at the time plays the major role in this time of exit from the nursery.

(Continued on page 100)

*This table includes all of the milks used in the 1,564 hospitals with single as well as those with two and three standard house formulas available for nursery use. Thus the per cent of totals will be more than 100.

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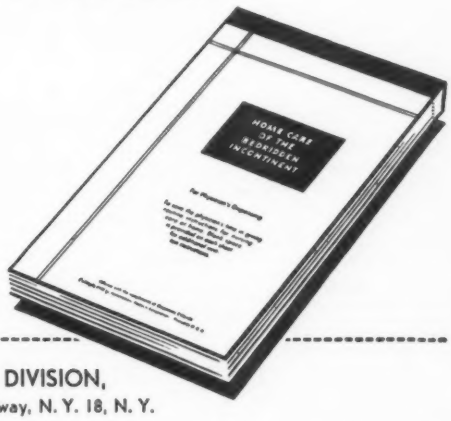

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HOSPITAL_____

ADDRESS_____

CITY_____ ZONE_____ STATE_____

BY_____

Table VI

Composition of House Formula

Region and State	Number with House Formula	Diluted Pasteurized Milk and CHO	Diluted Evaporated Milk and CHO	Evaporated Milk and Water	Skimmed Fresh Milk	Skimmed Powdered Milk	Premodified Prepared Formulas	Other
New England								
Hospitals	100	28	53	6	5	—	48	2
Births	122,039	34,868	74,561	6,049	4,382	—	48,740	1,710
Middle Atlantic								
Hospitals	247	43	169	11	4	2	88	5
Births	370,562	60,705	278,816	17,678	13,321	4,607	120,547	15,419
South Atlantic								
Hospitals	197	5	140	30	—	2	60	2
Births	236,436	6,460	176,742	40,778	—	2,545	62,599	2,256
East North Central								
Hospitals	305	28	190	47	7	—	101	4
Births	413,993	49,013	267,371	68,907	13,445	—	120,526	8,127
East South Central								
Hospitals	73	2	55	7	2	1	23	7
Births	83,044	2,809	67,215	6,781	2,435	861	28,435	9,462
West North Central								
Hospitals	198	15	131	19	2	2	81	1
Births	177,017	9,998	128,577	15,984	1,634	1,496	65,550	114
West South Central								
Hospitals	96	1	63	11	—	1	27	1
Births	118,845	1,755	72,775	11,749	—	94	38,898	512
Mountain								
Hospitals	92	1	59	23	1	—	30	—
Births	80,536	469	58,581	18,943	1,002	—	23,204	—
Pacific								
Hospitals	157	3	110	23	2	—	54	—
Births	217,958	7,797	148,775	37,493	3,123	—	66,396	—
Total U. S.								
Hospitals	1,465	126	970	177	23	8	512	22
Births	1,820,430	173,874	1,273,413	224,362	39,342	9,603	574,895	37,600
Armed Service								
Hospitals	99	—	29	4	—	—	73	—
Births	107,013	—	40,153	3,243	—	—	69,000	—
Total								
Hospitals	1,564	126	999	181	23	8	585	22
Births	1,927,443	173,874	1,313,566	227,605	39,342	9,603	643,895	37,600

OB DEPARTMENT

(Continued from page 98)

By utilizing the appended tables, it would be possible to compute the approximate amount of any specific milk food used in a hospital, state or geographic region, as well as to determine the varying customs and practices which obtain in different areas of the country.

It is acknowledged that not all of the newborn infants in hospitals with house formulas receive this standard mixture. Some are breast-fed and others get individually prescribed formulas. Of the 1,927,443 infants in hospitals utilizing house formulas, 21 percent were breast-fed, 16 percent were breast- and bottle-fed, while 63 percent were completely bottle-fed. There are no accurate data indicating how many infants continue breast-feeding for a month or longer after they leave the hospital. In some follow-up studies, as many as 65 percent of infants have continued breast-feeding for this length of time.

Few answers were obtained to the query of the questionnaire pertaining to the number of physicians recommending administration of a formula other than the house formula at the time the infant was discharged from the hospital. From the small number who did answer, it would seem that about 10 to 20 percent of physicians prescribe formulas other than

(Continued on next page)

Table IX

Average Age of Infants (in Hours) When Feeding Is Begun

Hours		Breast	Bottle	Not Specified
4	Hospitals reporting	4	0	19
	Infants included[1]	5,198	0	17,884
8	Hospitals reporting	33	7	123
	Infants included[1]	44,945	8,117	154,487
12	Hospitals reporting	127	21	815
	Infants included[1]	165,859	28,235	912,422
18	Hospitals reporting	8	7	128
	Infants included[1]	11,902	8,123	158,164
24	Hospitals reporting	19	138	589
	Infants included[1]	31,304	184,728	696,816
36	Hospitals reporting	2	21	21
	Infants included[1]	3,174	37,099	26,625

the house formula but do not so consistently enough to be numerically important.

It was incidentally ascertained that in the 1,876 hospitals reporting (2,130,618 infants) on this additional question, 49 nurseries had fresh human milk available and 65 had frozen supplies of this rare commodity. With few exceptions, this supply of human milk is used exclusively for premature infants.

COMMENTS AND CONCLUSIONS

Conclusions arrived at from the results of surveys indicating common practices in various branches of medicine are looked upon with a dim view in certain echelons of scientific research. The observation has been made that when a procedure is extolled by a majority, it does not, a priori, confirm its scientific accuracy. Weech, in a forum concerning information obtained by questionnaire in another field of infant feeding[7] expressed this view succinctly when he stated:

Table VIII

Number of House Formulas in Use and Milk Products Used

	Hospitals Reporting	Percent of Group
1 Formula		
Evaporated milk	846	65.8
Premodified prepared formulas	398	30.9
Pasteurized milk	40	3.1
Pasteurized skimmed milk	2	0.2
	1,286	100.0
2 Formulas		
Evaporated milk and premodified prepared formulas	153	70.5
Evaporated milk and pasteurized milk	37	17.1
Evaporated milk and pasteurized skimmed milk	17	7.8
Premodified prepared formulas and pasteurized milk	6	2.8
Premodified prepared formulas and pasteurized skimmed milk	2	0.9
Pasteurized milk and pasteurized skimmed milk	2	0.9
	217	100.0
3 or more formulas or nonclassifiable under above categories	61	
	1,564	

"Scientific truth is not established by taking a vote, no matter how democratic the procedure." However, the concept expressed by Weech has validity only when individual opinions are tabulated, i.e., physicians with varied scientific training and background. It would not be as applicable in *aggregate* or collective responses of many physicians in groups, such as those reflected in the designation of house formulas for infants in newborn nurseries. The exigencies arising from dogmatic decisions without regard to scientific principles would soon overtake the physician in charge of a nursery of newborn infants.

Table X

Average Age (in Days) When Infants Leave Hospital

Days	Hospitals Reporting	Infants Included[1]
2	28	34,869
3	244	262,844
4	488	542,721
5	877	1,044,368
6	181	236,827
7	63	87,780
Later	23	35,258

When the content of a food mixture is based on a sound respect for known nutritional principles, and has been successful over a long period of time in any specific nursery, that mixture would establish its status without further trial and error. By "successful" is implied the minimum number of gastrointestinal disturbances, adequate hydration and electrolyte balance, and sufficient caloric content to provide gain in weight.

Those who have had the responsibility of large or small groups of newborn infants in a nursery appreciate in full the many unhappy experiences which may befall them in even the most efficiently organized nursery. Clinical experience makes the physician in charge wary of the many unpredictable accidents that may occur, and will dictate caution in the choice of a milk mixture. This selection must be as dependable and "fool-proof" as possible, commensurate with the physician's concept of responsibility. For these reasons it would seem that a survey compiling the house formula most widely used would offer better

(Continued on next page)

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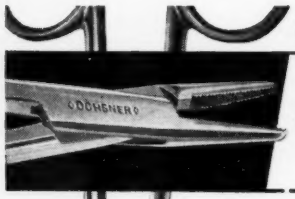

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guidance and credulence when tabulated in a study, than some approach not accompanied by the hazards of the feeding of newborn infants in a hospital nursery.

The historic value of recording these data is an added motive for its presentation so that future investigators in this field might have some accurate concepts of the clinical and scientific practices in the realm of infant feeding as it existed in the present era. There is also some challenge and satisfaction in listing the methods and technics used by contemporaries, and making these available for comparison, study and improvement. Of the 1,904 individuals who responded to the questionnaire, 1,901 asked to have reprints sent to them when the study was completed. The enthusiasm and interest contributed by those who answered the questionnaires was highly indicative of a desire to know what others were doing in their fields of responsibility.

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New Edition of OB Nursing Text Released

TEXTBOOK OF OBSTETRICS AND OBSTETRIC NURSING. Third edition. By Mae M. Bookmiller, R.N., and George Loveridge Bowen, M.D. Philadelphia: W. B. Saunders Company. 1958. 725 pp., illustrated. $6.

Revision of this standard textbook has incorporated advances and improvements in obstetrics and OB nursing which have occurred since publication of the second edition. However, controversial material and descriptions of as yet unproved methods of pain relief have been omitted.

In their preface, the authors point out that the biggest news concerning childbirth is the continued reduction in maternal and perinatal mortality and the increased number of births—a record 4,168,000 in 1956. "Spreading the gospel of what is good in clinical obstetrics," they note, "will further lower the maternal and perinatal death rates."

Featured in the text are original drawings by Frank Netter, M.D., and a section on the newborn, written by Harry Bakwin, M.D. New illustrations have been added and recent references incorporated.

Although the original organization of the text has been maintained, chapters have been combined where indicated for increased clarity. A glossary of terms used in the text is again included and also the self-evaluation examinations, which have been revised and expanded.

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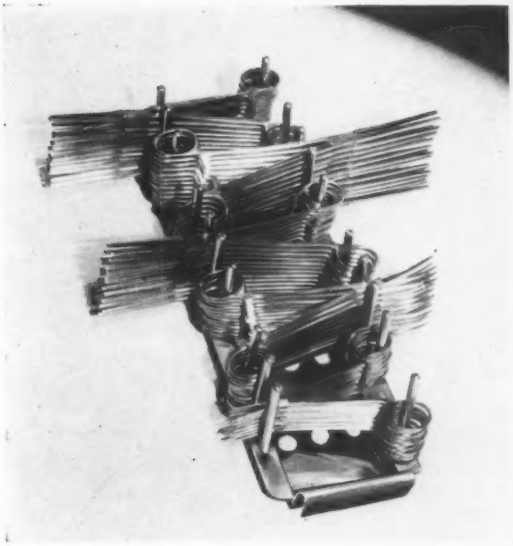

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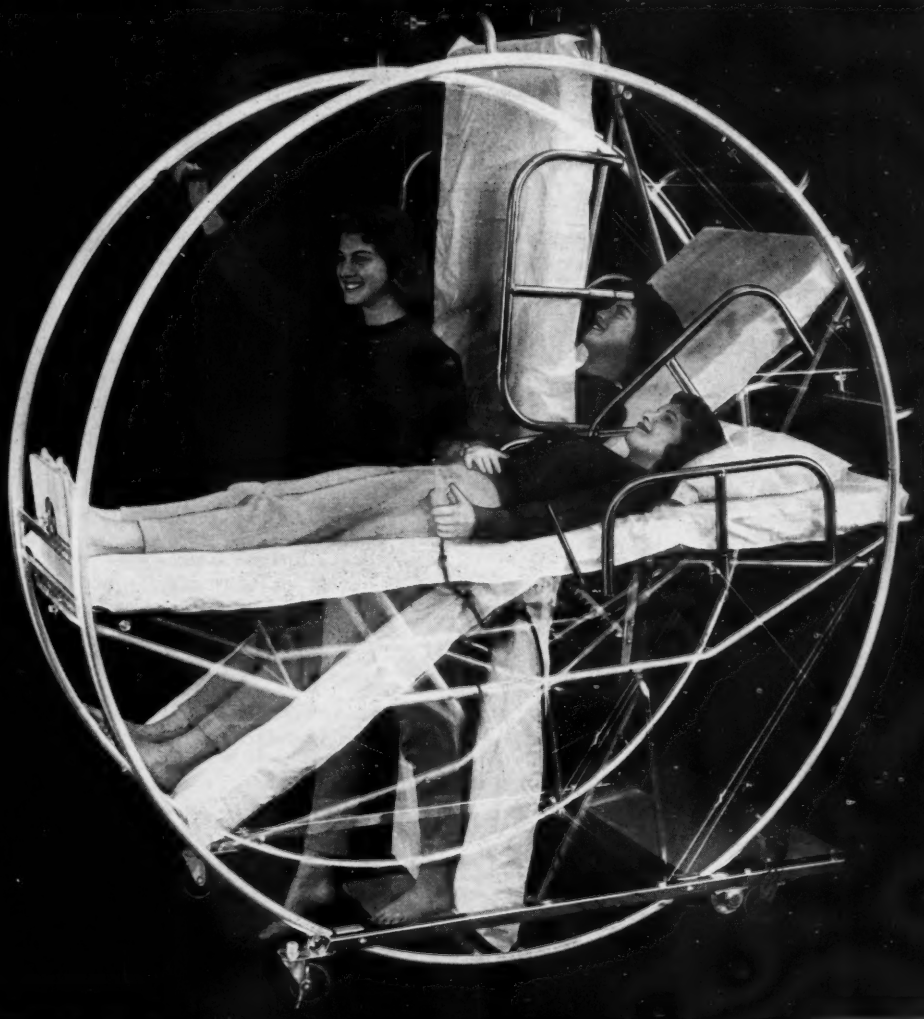

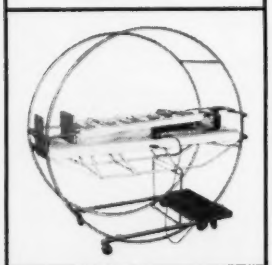

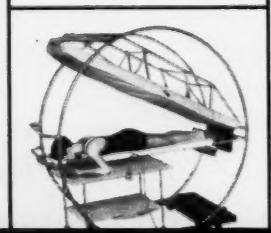

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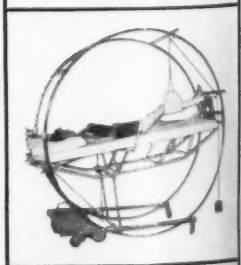

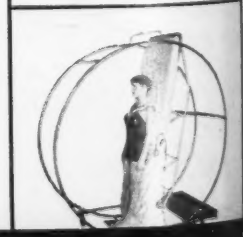

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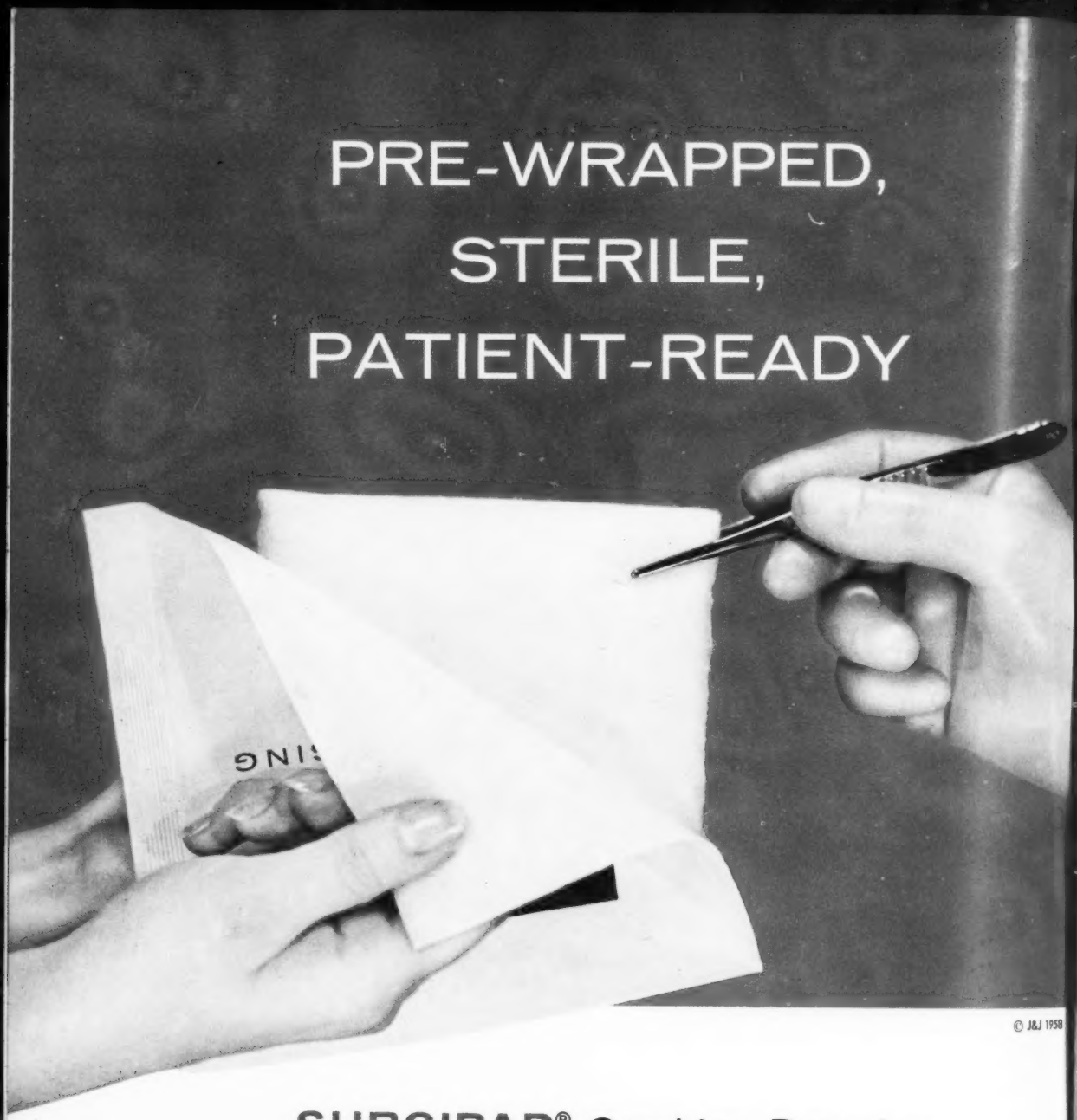

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Nursing Aide Manual

How to be a Nursing Aide in a Nursing Home. By Dorothy Erickson Reese, R.N., M.P.H. Washington, D.C.: American Nursing Home Association. 195 pp. $2.50.

This manual is designed to teach aides in nursing homes how to give simple care, with emphasis placed on helping patients achieve as much self-care as possible.

The 62 lessons represent duties commonly performed by aides, such as administering food and fluids, moving patients, and supervising patients' activities. Each lesson includes a brief introduction, instructions, and questions to help the aide review her performance. Special pointers on an aide's appearance, health, and conduct are included.

Mental Illness Facts

Basic Facts about Mental Illness. By Harry Milt. New York: Science and Health Publications. 1957. 31 pp.

The need of every citizen to have reliable information about mental illness and of health personnel to understand their potential roles as leaders has been recognized and met in this booklet.

Medical people and those in allied professions dealing with people in need or trouble will find the booklet a comprehensive fund of important, basic information about mental disease.

Technical information concerning neuroses, psychoses, and psychopathic personalities is presented with scientific soundness, in a readable manner. Also included are facts on treatment and recovery from mental illness.

Medical Detective Stories

The Incurable Wound and Further Narratives of Medical Detection. By Berton Roueché. Boston: Little, Brown and Co. 1957. 177 pp. $3.50.

Six narratives of medical detection combine skilled crime reporting, the fascination of a detective story, and the objectivity of science. Laymen and medical personnel alike will enjoy these true stories which first appeared in the *New Yorker*.

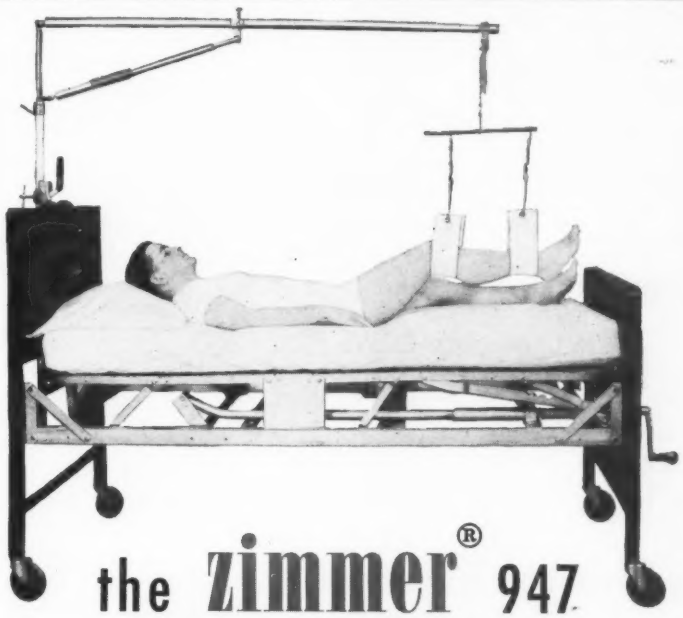
A harrowing story on rabid bats and their attacks on four people is well-documented and also includes a history of the rabies virus, attitudes toward it throughout the centuries, and the nature of the disease.

Subjects of the other stories include amnesia, carbon tetrachloride poisoning, a victim of periarteritis nodosa, a Poison Control Center, and aspirin intoxication, all with thorough background information on each particular subject.

Booklet Gives Facts on Nursing Education

The 1958 revision of the Vocational and Professional Monographs series pamphlet on "Nursing" is available for $1 a copy from Bellman Publishing Co., Cambridge 38, Mass.

Included is a history of nursing, and up-to-date information on requirements, education, and vocational opportunities.



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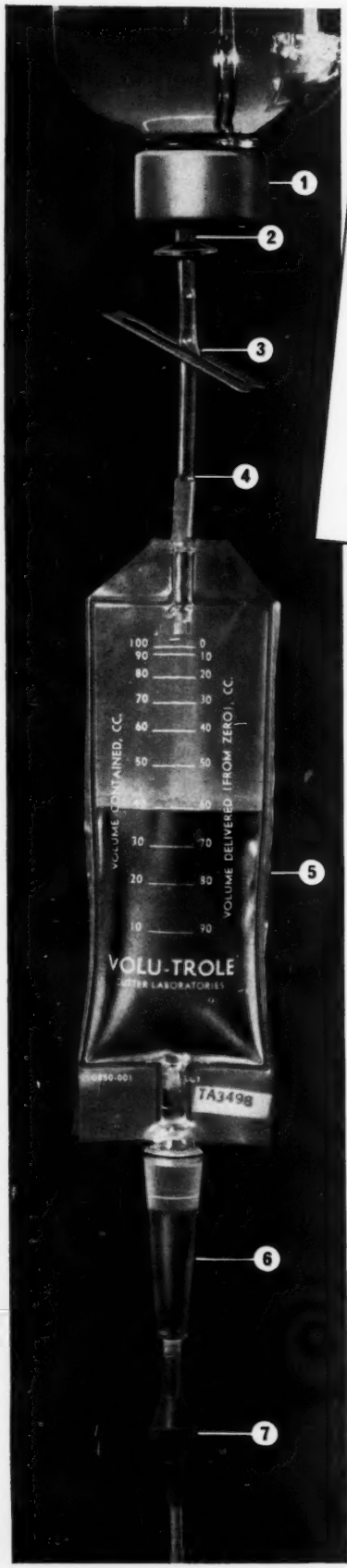

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New AORN Group Organized In Eastern New York

OFFICERS of the newly organized Association of Operating Room Nurses of Eastern New York are shown above at the group's second meeting, in Troy, N. Y., with Edith Dee Hall, R.N. (second from left), executive secretary of the national AORN. Miss Hall spoke at the meeting on the history of the AORN, organizational structure, and programming.

L. to r. are: Hazel Weiner, R.N., Albany Hospital, treasurer; Miss Hall; Hazel Milne, R.N., VA Hospital, Albany, president; Rosa Kennedy, R.N., Ellis Hospital, Schenectady, secretary; and Jane Millet, R.N., St. Mary's Hospital, Troy, vice-president.

Eighteen hospitals were represented at the first meeting in Albany. Sixty-four persons attended. Initial interest appeared to be so strong that further expansion of the organization is anticipated.

Texas Takes Over in February...

Houston to Host AORN's 6th National Congress, Shamrock-Hilton Hotel, Feb. 9-11

All roads will lead to Texas in February when members of the Association of Operating Room Nurses converge on Houston for what promises to be the association's biggest convention.

Preliminary program plans will be announced in the September issue of TOPICS. Oustanding personages in surgery are already slated for sessions, with new names being added to the agenda daily as comprehensive planning develops.

Exhibitors, too, will turn out in force, with the following companies already at work on their technical displays:

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Above: New officers are (l. to r.): Sister Mary James, O.R.S., St. Paul's Hospital, Dallas, board member; Mary Roberts, O.R.S., VA Hospital, Dallas, president; Mavis Pate, O.R.S., Medical Center, Tyler, secretary-treasurer; and Agnes Dornak, R.N., St. Luke's and Texas Children's Hospitals, Houston, board member. Not shown is June Fisher, St. Joseph's Hospital, Houston. Above, right: These nurses from St. Paul's Hospital, Dallas, were waiting for the afternoon session to resume. L. to r.: Myrlin Lively and Lily Aguilar, O.R. staff nurses; Ruth Tollefson, assistant O.R.S.; Imogene Adams, O.R. clinical instructor in the operating room.

Texas O.R. Nurses Hold Fifth Meeting

• The Texas Conference of Operating Room Nurses met at the Statler-Hilton Hotel, Dallas, in May for its fifth annual session in conjunction with the Texas Hospital Association (see June issue of HOSPITAL TOPICS for report on Texas meeting). There were 106 nurses registered. The group voted to change its name to the Texas Association of Operating Room Nurses. An abstract of one of the principal talks follows.

Inservice Education Improves Patient Care by Improving Work

Four Types of Programs Described

The purpose of inservice education is to improve the care of the patient by improving individual work performance. The purpose is the same for all nursing personnel—professional and nonprofessional. The objectives and content vary for the different levels of employees.

Content of an inservice program in the operating room is determined by what knowledge and what skills are needed to perform the work which the staff nurse is supposed to do. She needs full knowledge of the work she is to do and how she is to do it; knowledge of the responsibility involved; skill in planning and organizing the work of others; skill in teaching—every O.R. staff nurse is expected to do at least incidental teaching; and skill in handling employees.

There are four types of inservice education programs: orientation, on-the-job training, staff education, and leadership and special skills programs.

An orientation program is a planned introduction of the nurse to the job. It should be designed, therefore, to give her an over-all knowledge of the setting. Areas which should be included are orientation to the environment—situation and personnel; orientation to hospital and department policies; and orientation to her job. The program should be planned in advance and put in writing. It should be conducted by a competent person—one who is friendly and patient, who likes people and makes them feel at home. Emphasis should always be put on program content rather than on time. Staggered short periods produce better results.

On-the-job training is a continuation of the orientation program. Its purpose is to prepare the nurse to perform her job. Flexibility and sequence of content are important. It is quite likely that some material covered will be review material—but it should be reviewed and not taken for granted. Ample opportunity should be provided for questions.

Staff education programs should be the outgrowth of the nurse's functions and the needs of patients and the developments in the health fields. They are more effective when initiated and planned by the nurses. The staff should be motivated to participate out of interest rather than compulsion.

Leadership and special programs are given to provide preparation for special positions. Staff nurses are the most likely prospects for head nurses and supervisors.—*Edna Prickett, R.N.*, nurse consultant, American Sterilizer Co., Erie, Pa.

At left: Outgoing president Agnes Dornak (r.), with Betty Beaudry, assistant professor, Nursing Service Administration, University of Texas, Galveston. At right: Audrey Bell, O.R.S., Parkland Memorial Hospital, Dallas, board member, with speaker Edna Prickett, R.N., American Sterilizer Co., Erie, Pa., and new president, Mary Roberts, O.R.S., VA Hospital, Dallas.

CHANGING PATTERNS IN O.R. STAFFING

A symposium from the fifth national congress of the Association of Operating Room Nurses in Philadelphia

Preparing the Practical Nurse For O.R. Assignment

By Mary Ellen Yeager, R.N.*

EIGHT years ago, when the shortage of registered nurses became very evident, our hospital was faced with the necessity of providing a substitute. Because operating-room work is highly specialized, it was our feeling that the licensed practical nurse who had been trained in anatomy and nursing arts was the next best qualified.

Our surgical suite consists of eight large operating rooms with a sterilizing room servicing every two rooms, an anesthesia department, a tissue laboratory, an x-ray room, a darkroom, a recovery room, and a cast room for all of the surgical units.

We accommodate the following services: general, traumatic and orthopedic surgery; gynecology, which includes cesarean sections; urology; ear, nose and throat; oral; eye, and neurosurgery.

We have a 24-hour ambulance service and with it many emergencies. The operating room covers a 24-hour period, not as three separate tours but as a continuous unit, each tour supplementing the other. Each group is responsible for the accomplishment of specific duties.

We have an eight-hour day and a five-day week.

After it was decided to train practical nurses for operating room work, those who wanted to work in the operating room were carefully selected from the hospital personnel by the director of nursing service and the operating-room supervisor. They were screened thoroughly as to physical and mental health and emotional stability. Ability to work as a team and to get along well with others was considered of prime importance before htey were assigned to the operating room for training. The first six weeks were considered a probation and elimination period to further observe their capabilities.

At the beginning of this program, many problems arose that we had to overcome.

The graduate nurse felt that part of her traditional duties were being taken away from her. However, as the program progressed, she realized that with the added assistance she was able to devote more time to specific duties, references, and theory.

The first practical nurses found the various procedures unfamiliar and therefore complicated. It became apparent at this time that more simplified instruction was necessary.

To accomplish this, we did the following:

1. We revised our procedure manual. We simplified all procedures by listing types of operations and their definitions, indexed supplies, instruments, and equipment needed for the various operations, and provided visual aids such as illustrations of instruments and diagrams of setups.

2. We carded and indexed sutures needed for various types of operations.

3. We assigned to separate cabinets instruments peculiar to each service.

4. We made available at a prominent focal point a reference center for current literature, policies, and specific duties.

5. We posted in a prominent spot in the workroom an index of the preparation and sterilization of all packs, trays, basic sets, and gloves.

Not only have these steps proved beneficial to the training of the practical nurse in the operating room, but they have been found to be a valuable aid and asset to the registered nurse.

*Operating room supervisor, Elmhurst (N.Y.) General Hospital.

Upon assignment to the operating room, the practical nurse is oriented in the following ways:

1. She is introduced to each member of the staff, and given a preliminary tour of the entire unit.

2. She is informed as to the policies, rules, and regulations governing hours of duty, relief, deportment, and ethics, and the importance of the service to the patient and to the hospital.

3. She is assigned to the workroom area, and is taught:

a. The care and preparation of supplies and equipment.

b. Preparation of linen, including sorting, folding, and assembling of packs.

c. Preparation of gloves, including cleaning, testing, powdering, and packing.

d. Care and operation of sterilizers and proper technics for sterilization of packs and solutions.

e. Storage and care of instruments and the selection and assembling of various instrument packs.

f. Basic information about the functions of the cast room and x-ray rooms.

This orientation program requires approximately 10 weeks. During this time the nurse formulates the foundation for the more advanced work.

The next assignment is general surgery, in which the trainee is taught, under supervision, to act as the circulating nurse. We emphasize at this time that a good circulating nurse is as important as a good scrub nurse. We also instill in the student's mind the idea that she is becoming part of a team. The idea of teamwork is emphasized throughout the training program. It gives the student a feeling of belonging, which enables her to feel secure and strive to do her best work.

During the assignment to surgery, the student is taught:

1. How to prepare a room for surgery.

2. How to assist the scrub nurse, doctors, and anesthetist.

3. How to receive a patient.

4. What to look for on the patient's chart.

5. How to take care of blood for transfusions.

6. How to care for specimens.

7. How to record information on charts and permanent records.

8. How to return a patient to the recovery room or surgical unit.

A special effort is made to explain the reason for doing things as taught and why it is necessary for the maintenance of routine. The individual is encouraged to ask questions if she needs further information or clarification.

When this assignment has been performed satisfactorily, the student is taught to scrub and is gradually allowed to set up the surgical unit and assist at the operation with a fully trained member of the staff in attendance. She is first assigned to minor operations and later to major operations.

COVERS ALL SERVICES

When sufficient time and experience prove that the student is thoroughly acquainted with this service, she is assigned to another service, until she has covered all services.

On each service, the student is taught the necessity for teamwork, the importance of good patient care, responsibility for cleanliness and replenishing of supply cabinets and the resterilization of packs, and the importance of clean surroundings. Our motto is: "A clean house is a healthy house. Let's all work together to maintain a healthy operating room."

The licensed practical nurse is also given, by the educational director, 26 hours of class work in the administration of drugs and narcotics. She is given one week's instruction, on the job, in the care of the patient in the recovery room.

Following approximately 10 months of day-duty experience, the student is assigned to the first tour of duty, from 11:30 p.m. to 7:30 a.m., and to the third tour, from 3:30 p.m. to 12 midnight. On these two tours of duty, full responsibility is given for meeting emergency situations.

Thus far, approximately 50 licensed practical nurses have taken the opportunity offered to learn operating-room technics. Some have gone on to become registered nurses; some have left us to work at other hospitals, or to raise a family, while others have stayed with us as respected members of our staff. We feel that we have accomplished a worthwhile project, and the efforts have been soul-satisfying.

The practical nurses have all obtained a well-rounded program, and with the assistance of the visual aids and the continued inservice training program they have developed into efficient and reliable operating-room nurses. It has been proved at our hospital that the licensed practical nurse, given the proper teaching by the registered nurse, can take a place in operating-room work.

The success of any well-planned program depends upon the co-operation of the entire staff. The graduate nurse must be willing to accept her professional responsibilities in teaching and training the licensed practical nurse. Only through teaching, co-operation, and understanding can we reach our objective—better patient care.

(EDITOR'S NOTE: The manual prepared by Miss Yeager and used in the training program has been published by G. P. Putnam's Sons, New York City. Price: $4.50.)

Training Program for Technical Aides

. . . in a Civilian Hospital

By Sister Mary Ida, H.H.M., R.N.*

THE training program for operating-room technicians at St. Elizabeth's Hospital, started in August, 1952, has four general objectives:

1. To prepare well-qualified, nonprofessional personnel in operating-room technic and organization.

2. To promote the operating-room technicians' knowledge of surgical asepsis and to develop manual dexterity, thereby enabling them to render to the patient and to the surgeon the best possible service.

3. To encourage self-development and provide job satisfaction.

4. To prepare the operating-room technicians to become an integral part of the surgical team.

Standards and principles must be determined for the selection and assignment of the technicians.

1. Selection must be made according to definite qualifications. This point cannot be over-emphasized, for unless these persons are exceptionally well-screened, the strength of the program will be weakened, and the safety of the patient will be jeopardized.

2. The educational program must be well planned and organized. Subject matter should be outlined, teaching methods described, class hours scheduled, and adequate provision made for supervision during and after the initial training period.

3. All assignments given to technicians, either during or after the training period, must be in accordance with their capabilities and proficiencies. If they should show a special aptitude and liking for a particular field, they are given the opportunity to remain in it; however, the over-all needs of the department must be kept in mind.

4. Probably the most important principle is that throughout the training program they are always under the guidance and supervision of a registered professional nurse.

REQUISITES

General good health and reputable character are prime requisites for technicians. The best age range is between 18 and 35. While women will be in the majority of those making application, young men are valuable as technicians. A high-school education is preferred; however, a person who does not have one for a good reason but seems to be a likely candidate is given a trial.

The candidate must have the ability to comprehend the course content and the willingness to spend four weeks as an aide prior to the training period. During this time the supervisor observes the technician to see whether or not she is capable of becoming an asset to the operating room team. The candidate also has the opportunity to become adjusted to the department and can better judge whether she wants to continue with the program. This initial period as an aide has prevented many dropouts before the formal instruction period begins, and has weeded out many undesirable candidates.

The technician should have the personality and temperament appropriate for operating-room work, and have a neat personal appearance. The student technician must understand that the objective of the program is to provide on-the-job training which will give her technical skill in surgical procedures, and will qualify her to give service to the hospital. It is not an educational program for a professional position outside.

The candidate who appears to have superior qualifications and expresses a desire to do more than this category of worker is permitted to do should be guided into one of the professional nursing programs.

Sources from which candidates can be recruited include graduates from local high schools; capable aides already employed in the hospital; premedical and medical students; veterans who have been trained in the military services for this type of employment, and others who have become interested in the program.

The methods most commonly used in teaching this group are:

- Formal classroom instruction—used frequently in the beginning of the course, and directed to the needs and learning level of the technicians.

- Planned observation, demonstration, return demonstration, and supervised practices—carried out until the technicians are able to perform the procedures effectively and easily.

*Operating room supervisor, St. Elizabeth's Hospital, Youngstown, Ohio.

• Individual conferences and discussion groups to determine the difficulties of the technicians. Sometimes it may be necessary for the instructor to plan remedial work to help a technician grasp the required subject matter to keep up with the group.

• Appropriate reference books available in the department. Required reading assignments from them supplement the technicians' class work.

• Periodic examinations to see whether the technicians are grasping the theoretical knowledge. Close observation in conjunction with the examinations is used to measure the achievements of the students.

• Experience records, kept by the technician. These provide accurate data of experiences and technical performances.

• Visual aids. These should be used extensively. Photographs of instruments help immensely in teaching the identification and placement of instruments. Specifications of doctors' preferences set up in suture manuals insure efficiency and staff satisfaction, and also reduce the waste of sutures. Anatomical charts and models are excellent for teaching the organs of the body. A well-organized procedure manual is invaluable not only to unify the surgical procedures but to promote a high degree of accuracy and efficiency.

The teaching and supervising of the technicians in their initial training period has been done by the operating-room supervisor, head nurse, and clinical instructor. After the student technicians have acquired a certain basic knowledge of the principles of aseptic technic, they are placed under the supervision of a staff nurse for carrying out their assignments.

During the preliminary period as an aide, the future technician should learn patient approach, regulations of the institution, rules of conduct and decorum, and certain basic principles necessary to all surgery personnel. Although their work is almost entirely a matter of technical skills, the philosophy of the hospital—the patient-centered approach—is the underlying principle on which everything else is built. Only by meeting the physical, psychological, and spiritual needs of the patient can total care be given.

After the preliminary period, the employees who have the ability and meet the qualifications are advanced to the nonprofessional group and are known as student operating-room technicians. Formal classroom work is begun, including 50 hours of planned instruction and demonstration. An average of two to five hours of instruction is given weekly for 16 weeks. We begin with the simplest procedures and principles and gradually work to those which are more complex.

During this period of training, the necessity of following directions is stressed, and the student technicians are observed very closely. They are taught why tensions exist, how to remain calm, and how to form an objective attitude so that they will never allow personal feelings to interfere with good patient care. They scrub with a graduate nurse until they prove themselves capable of scrubbing alone. They are advanced to more difficult cases as their knowledge and skill increase.

In teaching the technicians it may become apparent that one will excel and enjoy working in a particular field, and will not be able to adapt to more complicated procedures. If this should happen, the training program for more advanced work is discontinued, and intensive instruction is given in the chosen field. Technicians who demonstrate superior skill should be given more concentrated training in complex technics, and added responsibilities.

After completing the course of instruction, technicians are qualified to carry out many assignments. The duties of circulating technicians may include such tasks as preparing the operating rooms; setting up sterile tables for the scrub person; remaining with patients undergoing anesthetics; adjusting the ether screen; focusing the operative light; supplying the surgical team with the necessary supplies; assisting in applying dressing or plaster casts; cleaning up after the operation, and returning all articles to their proper places. However, the operating-room supervisor should be aware that the technician, although assigned to circulate, is a supplement to the professional nurse and cannot assume full responsibility of an operating room alone.

Scrub technicians can set up sterile tables; assist with draping the patient; supply the doctor with the instruments, sponges and sutures; keep the instruments clean and in place; take a sponge count with a graduate professional nurse, and take care of instruments and other supplies after the operation.

When the technicians can perform the above duties efficiently, their service and helpfulness are appreciated by the doctors and graduates. However, their status is still that of nonprofessional workers. They are restricted in the following ways:

1. They must always be under the guidance and supervision of a graduate professional nurse.

2. They may not take a sponge count with another technician. It must be done with the professional nurse.

3. They may not be given administrative responsibilities and are never left in charge.

4. They are not permitted to give any medications whatsoever.

For an effective evaluation of their accomplishments, statistics were collected during a two-month period at an interim in the rotation schedule when there were no student nurses in the department. Here are actual data from a technician's record covering these two months. She scrubbed for a total of 80 cases including:

2 abdominal perineal resections

8 abdominal hysterectomies

(*Continued on next page*)

15 appendectomies
5 cesarean sections
8 cholecystectomies
6 gastric resections
6 hemorrhoidectomies
8 herniorrhaphies
4 nephrectomies
3 radical mastectomies
2 radical neck dissections
3 saphenous ligations and strippings
2 uterine suspensions
4 sympathectomies
4 thyroidectomies

Another technician, who scrubbed for minor cases, scrubbed for 200 cases in a two-month period, including:

8 bronchoscopies
6 excisions of maxillary cysts
6 nasal polypectomies
12 submucous resections
32 teeth extractions
136 tonsillectomies and adenoidectomies

The technician also works evenings and takes night call, but again under the supervision of a professional nurse.

When medical students are employed in the operating room as technicians, the preliminary period as an aide is omitted. We do not teach them to circulate nor to do some of the other duties of the technicians, because of the limited employment period.

In initiating a program it is advantageous to start with two carefully chosen persons and give them a thorough training period. The program should be explained to a few of the doctors and their permission asked to assign a technician to scrub for their operations. The technician should be assigned to the same doctor until she has gained confidence in herself and has acquired the manual dexterity satisfactory to the doctor.

Each program should be adapted to the particular hospital and its individual needs. After a few have been trained and are employed, the training program should be activated only as necessary to provide for replacements.

Since we have had technicians, we have been able to improve the clinical experience of student nurses. We no longer depend on them for nursing service, but center their program on an educational basis. The doctors are well satisfied with the technicians, because they become well adapted to the specific technics, and are a constant part of the team pattern.

We do not have a sufficient supply of professional nurses to completely staff our operating room, but by using technicians we have been able to give our graduate nurses more challenging administrative and supervisory duties, and have assigned the fundamental but necessary functions to the technicians.

In an attempt to determine the current role of the technicians in the changing pattern of operating room staffing, I sent questionnaires to 120 hospitals in 35 different states. Of the 85 hospitals which responded, 55 have a program for technicians. This total does not include hospitals which are employing practical nurses as technicians.

The answers showed that over the past 10 years there has been a decided growth. The greatest impetus has been since 1952. Nine programs were begun between 1947 and 1952; from 1953 to 1957, 46 programs were started, five times as many as during the previous period.

This program is not incompatible with the clinical period of the professional student nurse in the operating room; its establishment seems to be a necessity because of the limited time the student nurse spends in surgery and the necessity for the professional student to have a more intensive theoretical training rather than technical skill. Of the 55 hospitals which have the program for the technicians, only four do not have professional students. From the fact that the average length of stay for the professional students is from six to eight weeks, it is evident that the technicians are supplementing the services needed.

The hours of formal classroom instruction and demonstration for technicians vary greatly. There is no consistent pattern. The most frequent choice for the training period is six months. Technicians are being used to scrub and circulate for major and minor procedures in almost all the reporting hospitals.

The ratio of technicians to registered nurses is interesting. It varies from one to one, to one operating-room technician to six registered nurses. In a very few hospitals the ratio is reversed, and there are two operating-room technicians to one registered nurse.

All but three responses stated that the doctors were pleased with the program, and the majority answered that the operating-room technician program was accepted by the graduate nurse staff. The reason for acceptance was that the program provided continuity of service to fill a need.

Many hospitals which do not have a training program expressed the desire to start one.

The increase in operating-room facilities, the greater number of operations (especially those of a new or radical nature), the insufficient number of professional nurses, the shortened clinical experience of student nurses—all challenge the operating-room supervisor to seek the best way to meet the demands of these dynamic times. The operating-room technician program is one answer. The supervisor will find technicians a welcome supplement to her staff.

Training Program for Technical Aides

. . . in an Army Hospital

By Capt. Marion L. Rolph, ANC*

THERE are two types of educational programs in U.S. Army hospitals. The first type is informal on-the-job training that may be carried out locally at the ward level of any duty station. The second type is formal training under the direction of the Office of the Surgeon General and is conducted at Brooke Army Medical Center, Fort Sam Houston, Tex. The applicatory phase of this formal program is conducted at selected Army hospitals.

The majority of personnel selected for formal training are new to the service. They may be draftees, first-year enlistees who have finished their basic combat training; or they may come from the WAC training center and the Air Force training units.

Their educational and environmental backgrounds are as varied as those of any cross-section of American people. They may have college degrees, or they may not have finished high school. They may have enlisted because they were promised a choice of schools, or they may have been selected to fulfill a quota.

At best, their motivation for learning may be very low. Therefore, our first problem is to motivate the student, and our second problem is to teach on a level of the majority without losing the interest of the minority.

After basic combat training, our students attend a medical training course that consists of eight weeks of simple nursing procedures and field medical training. Since the soldier must be trained for war as well as peace, the larger part of this eight weeks is taken up with field medical training. The lectures are given in large groups, and there is little time for individual problems. The groups are broken into smaller sections for their practical exercises.

The students are given general technical aptitude tests. Their scores indicate their ability to learn technical material. Those with scores of 90 or above are sent to specialist schools—operating room, medical, neuropsychiatric, laboratory, x-ray, social work, and clinical psychology. Students with scores below 80 remain at the lowest level of medical technician and are utilized only for simple tasks.

*Instructor, operating room, Valley Forge Army Hospital, Phoenixville, Pa.

The operating-room specialist student must satisfactorily complete the medical training school and must have a general aptitude score of 100 or above. He must be in good physical condition, because he will be required to stand for long periods of time. He must be emotionally stable and free from psychiatric disorders. The job he is about to learn requires considerable attention to detail, adaptability, and versatility to accomplish work assignments and to function as a member of the operating-room staff.

In a 12-week course we attempt to familiarize the student with the essentials of total patient care, work in the central materiel section, and duties of an operating-room specialist. Considering the length of the course and the student's lack of previous education and experience, we can only hope to lay a foundation and to stimulate motivation for future learning in a work situation.

The Phase I Operating-Room Procedures course, conducted at the Army Medical Service School at Fort Sam Houston, Tex., consists of four weeks of didactic training and includes 140 hours of academic subjects, such as anatomy, physiology, pharmacology, medical and surgical nursing care, and neuropsychiatry.

Most of this time is spent in lecture periods, because the classes have 30 or 40 students, and again time does not permit individual attention. However, 14 hours of practical exercise are conducted in a mock situation. There is a nursing-arts classroom and a model operating room. Smaller groups are formed for these classes, and the students learn to make beds, take temperatures, pulse and respirations, take blood pressures, give bed baths, administer injections, and catheterize patients.

Although lectures and demonstrations of operating-room technics are limited, they include scrubbing, gowning, gloving, identification of basic instruments, positioning of patients, and surgical preparations.

During the four weeks, there are three one-hour reviews, examinations, and critiques.

As members of the armed services, the students also have 36 hours of nonacademic subjects, such as inspection, physical conditioning, character guidance, and troop information. They must have time

(*Continued on next page*)

for processing into and out of the school and for graduation exercises.

APPLICATION OF TRAINING

The second phase of applicatory operating-room procedures is conducted at 25 Army hospitals designated as applicatory training stations.

Until he starts this phase, the student very likely has not been inside a hospital except as a patient or casual visitor. He has been hearing about "total patient care" and "patient-centered care" for several weeks. Now he has an opportunity to practice the principles and procedures he has been learning. This practice is planned, supervised, and supplemented with further demonstrations and lectures.

Each hospital receives from two to eight students at a time. Teaching now becomes individual, and aptitude and performance can be evaluated.

The student first practices the care of the patient on the ward by working in the preoperative and postoperative sections. He learns to know and identify the patient as a real person with very real problems. He learns such procedures as irrigations and inhalations, administration of nose drops and throat gargles, administration of oxygen therapy, and the precautions and care of equipment used in this therapy.

He learns to assist the doctor with spinal punctures and the changing of surgical dressings. He becomes familiar with such equipment as the suction machines, Stryker frame, Foster bed, and the various forms of respirators.

After two weeks of preoperative and postoperative care, the student is assigned to the central materiel section. He is first oriented to the department and introduced to the duty personnel. He becomes acquainted with the physical setup and the established routines. He works in each section a day or two at a time and learns to use and care for equipment such as the glove dryer, tube washer, syringe washer, needle cleaner, and water distiller. He folds, packs, and wraps linen for both ward and surgical use. He learns to use and maintain sterilizing equipment.

The final four weeks are allotted to practical application in an operating-room department. Again the student is oriented to the department. He is introduced to the study personnel and is taught how to dress and how to conduct himself as a member of the operating-room team. He is told what is expected of him and what he may expect to accomplish.

He again attends classes of lecture and demonstration, but this time there is an immediate follow-up of practical application during actual operations. He is given the duties and responsibilities of a circulator by lecture and demonstration. He returns the demonstration first in a classroom and then in an operating room.

His case experience is as varied as the daily schedule permits. Because the clinical instructor cannot supervise all of the students at the same time, she assigns each student to a specialist, who carefully guides and assists the student through his circulating duties and pays particular attention to his sterile technic. Thus, the instructor has time to observe all of the students and to make notes as to where more practice and demonstration are needed.

Included in the circulating duties are positioning and transportation of patients, sterilization of instruments, sponge counts, care of specimens, septic and aseptic technics, and care of special equipment.

The second or third week the student learns to scrub, gown, glove, and set up a sterile table. This is done first in class and then in the operating room. However, for scrubbing in an operating room, the student is assigned to a staff nurse. His class preparation for this assignment includes identification and handling of instruments, sutures, and needles.

As he gains experience, the pieces of knowledge begin to fall into place. He is graduated at the end of the final eight weeks. If practical application and close supervision reveal a definite lack of aptitude, the student reverts to his previous status of medical aid man.

All operating-room specialists do not work in an operating room. Use of these specialists interchangeably facilitates the solution of our staffing problems. Moreover, we hope we can develop a specialist with broad experience and understanding of total patient care.

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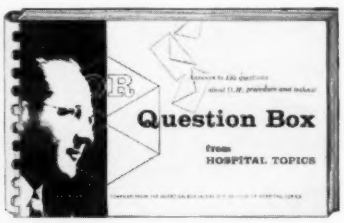

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SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Suggestions will be welcomed for subjects to be covered in future issues.—The EDITORS.

Keeley, John L., and Schairer, Arne E.: "A Simple Collection Arrangement for 'T' Tube Drainage." *Am. J. Surg.* 94:120, July, 1957.

A sterile rubber glove is used as an economical collecting bag for bile draining through a "T" tube. The tube is fixed to the skin with a suture which, besides anchoring the tube, serves as a warning device by causing the patient pain if the tube is pulled out of position.

A glass tube connects the tube to the folded cuff of the glove, and each end is tied snugly. No opening is needed for the escape of air. As the glove fills, it is emptied by aseptically amputating the tip of one glove finger. When the glove is emptied, the fingertip is stitched together.

Three disadvantages are leakage around the connections, bursting of a distended glove if the patient rolls on it, and leakage from the amputated fingertip if ligatures are not well placed.

Darmady, E. M., Hughes, K. E. A., and Tuke, W.: "Sterilization of Syringes by Infra-Red Radiation." *J. Clin. Path.* 10:291, Nov., 1957.

Clean, assembled syringes are sealed in appropriate containers and placed in single layers on trays of galvanized sheet metal, 17x11x1.5. The trays are loaded on a moving belt which passes through an insulated tunnel heated with four infrared projectors. The syringes are exposed to 180° C. for 11 minutes and emerge sterile, sealed, and ready for use.

The heating time of syringes of different sizes in different containers was tested, and it was found that a 2-cc. syringe in a Pyrex test tube reached 180° C. in three minutes. The same size syringe in a dull black, anodized container reached 180° C. in three and one-half to four minutes. In a dull aluminum container, the 2-cc. syringe required four and one-half minutes to reach this temperature.

A 20-cc. syringe heated to the same temperature in four minutes in a Pyrex tube; five minutes in a dull anodized container, and six and one-half minutes in a highly polished black container.

Despite its quick heating time, Pyrex was eliminated because of the inevitable breakage and high cost of replacement, and to equalize the heating time, 2-cc. syringes were packaged in dull aluminum containers and 20-cc. syringes in aluminum containers painted mat black.

The maintenance of even, steady heat in the "sterilizer" appeared to be subject to control by critical location of the projectors and the use of main voltage stabilizers or thermostatic control of each heating element. Limiting the load to single layers of containers assured even heating of the syringes.

The process was tested bacteriologically, using dried, spore-bearing earth and thermocouples attached to test syringes to measure time and temperature. Subculturing onto solid media was done despite the apparently clear, sterile fluid cultures, and in several instances growth was attained.

In 128 experiments, varying times and temperatures were used. These are the authors' conclusions: (1) The temperature *must* exceed 160° C.; (2) it *should* exceed 180° C.; (3) there is apparently no direct relation between the length of time of exposure and temperature reached and the bacteriological results; (4) when the temperature exceeded 180° C. for more than seven minutes, syringes were consistently sterile.

Although machines for this type of sterilization are becoming commercially available, the authors point out that "no authoritative body has yet laid down a standard organism for test purposes, and therefore the actual temperature and length of time necessary is still a subject of debate."

Wechsler, H., Lattimer, J. K., Rosenblatt, G., and Goldman, M.: "Studies on Sterilization of Cystoscopes." *Am. Rev. Tuberculosis and Pulmon. Dis.* 76:909, Nov., 1957.

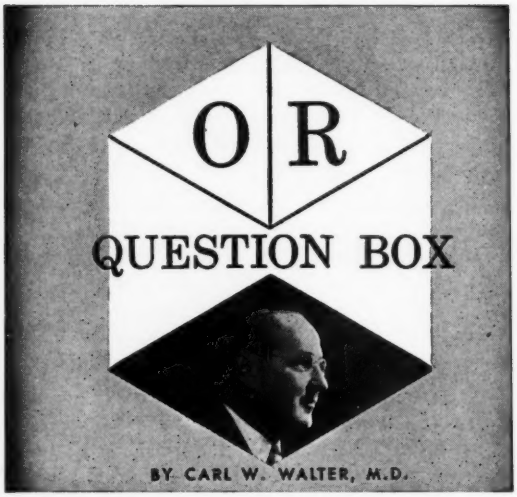
Cystoscopes present many problems in disinfection, not the least of which is the ever-present potential hazard of the *Mycobacterium tuberculosis*. In this study, five disinfectants were tested for tuberculocidal properties: an iodophor, three orthophenol phenolic compounds, and an alcoholic-formaldehyde solution. Also included were studies with formalin solution.

Cystoscopes were inoculated with pathogenic *M. tuberculosis* recovered from patients with renal tuberculosis. After immersion and culture, it was found that one percent formaldehyde is not effective after 30 minutes' exposure. Five percent formaldehyde was effective in 15 minutes. The alcoholic-formaldehyde three and one-half percent solution was uniformly effective after five minutes' exposure.

Two orthophenolics were effective after 30 minutes; the third, after one hour. There is some conjecture that some strains of *M. tuberculosis* may be resistant to this agent. The iodophor was consistently effective in 30 minutes and had excellent detergent properties.

The authors stress the importance of careful rinsing of instruments soaked in formaldehyde

(*Continued on page 123*)



Assisted by Dorothy W. Errera, R.N.

Q. We are using sutures sterilized in a germicidal solution containing formaldehyde. During the course of the day, the level of solution drops as sutures are removed. Would the remaining sutures in the jar be considered contaminated if not covered by the solution, or will the germicidal vapors maintain sterility during an average day's use?

A. The germicidal activity of formaldehyde vapor in a closed container approximates that of the formalin solution. Depletion of solution during an average day of use is not serious. The volume must be replenished at regular intervals, particularly when unused; uncontaminated suture tubes or packs are returned for disinfection.

Q. We are concerned with the proper procedure for the care of pick-up forceps. What kind of disinfecting solution do you recommend, and how often should the forceps be autoclaved?

A. Forceps should be steam-sterilized at regular intervals. The germicide selected for use with sterile transfer forceps should be volatile so that the vapors disinfect the inner side of the lid of the container as well as the legs of the forceps above that part submerged. An alcoholic-formaldehyde solution is most suitable.

When sterile transfer forceps are used in areas in which the toxicity of the solution if drunk would be a hazard (possible areas are pediatric wards, outpatient departments, and psychiatric departments), it is better to forfeit a degree of security in asepsis in the interest of nontoxicity. Under these circumstances, a 1:750 aqueous solution of a quaternary ammonium compound is acceptable. This same solution would be suitable for use in ophthalmologic surgery in which alcohol and formalin in residual solution on the forceps would be likely to injure tissues.

Transfer forceps containers must be inspected daily to be certain that the proper quantity of solution is present. When a quaternary ammonium compound is used, the germicide is discarded and replaced daily; when the alcohol-formaldehyde solution is used, the volume is merely replenished daily.

Q. We are contemplating the cleaning and sterilizing of patients' thermometers in the central supply room. Do you have any suggestions or recommendations for this technic?

A. You will find it more practical and economical to assign a thermometer to the individual patient. This thermometer can be stored at the bedside in a small jar containing one of the quaternary ammonium compounds. The thermometer must be wiped thoroughly with a bit of tissue following removal from the orifice. It can then be stored immersed in the germicidal solution until used again.

Upon the patient's discharge, his oral thermometer must be treated with a tuberculocide such as 70 percent ethyl alcohol, a solution of Wescodyne, or one of the chlorinated orthophenyl phenols.

Q. Is a solution of Wescodyne 75 p.p.m. injurious to Lucite and Tygon?

A. The Wescodyne solution is not injurious to Lucite or Tygon, but it is not an efficient sterilizing agent for disinfection of the lumen of Lucite parts or Tygon tubing because any bubbles of air trapped in the lumen will prevent access of the germicide to the wall of the material, and hence there will be areas in which disinfection does not occur. Ethylene oxide is far superior for this purpose, because as the biomechanical equipment is permitted to warm to room temperature, the gas volatilizes and will sterilize the portions of apparatus in contact with residual air.

Q. What is your opinion on picking up with the fingers cotton pledgets which have been soaking in a disinfectant solution?

A. The most widespread technic for dispensing cotton pledgets or sponges which have been immersed in a germicide is that of using a pair of sterile transfer forceps. The sponges can be placed on the tray to be picked up subsequently by the fingers for scrubbing the skin. In blood donor clinics, it has become widespread practice to hold the sponge or pledget in the transfer forceps while the skin is being scrubbed. Either technic described is satisfactory.

Fingers should not be used to remove the immersed pledgets from a germicidal solution because the skin elutes germicide selectively from the solution, leaving a lesser concentration behind each time the solution is entered. In this way the sponges carry increasingly dilute germicide and ultimately only distilled water to the field.*

*For information on adsorption, see "Investigations on Adsorption of Benzalkonium Chloride U.S.P. by Skin, Gloves, and Sponges," by Kundsin, Ruth B., and Walter, Carl W., *A.M.A. Arch. Surg.* 75:1036-1042, December, 1957. Reprinted in HOSPITAL TOPICS 36:108-113, February, 1958.

What every O.R. Nurse should know about A·S·R STERISHARP blades

Q. *What is a SteriSharp?*

A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT, 380 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada—A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

Literature and samples for your evaluation available upon request. If you have further questions—ask us.

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●*Guest editor this month is Mrs. Lillian Sholtis Brunner, R.N., consultant in medical and surgical nursing, Bryn Mawr (Pa.) Hospital School of Nursing. Mrs. Brunner is also co-author, with Eldridge Eliason and L. Kraeer Ferguson, of* Surgical Nursing *(J. B. Lippincott Co.)*

Q. How can operating-room nursing be patient-centered?

A. Operating-room nursing *is* patient-centered, since the very existence of the operating room depends upon the existence of a patient. The *course* in operating-room nursing, which is designed to teach students of nursing, be they basic or graduate, can be patient-centered too.

A few years back, when the principles of asepsis were defined, emphasis was and still is placed on the extreme importance of practicing a technic which is as nearly perfect as is humanly possible and practical. This is still vital, for the very life of a patient may be jeopardized if there is laxity in carrying out the proper technic.

Emphasis in teaching programs should be placed on the *reasons for* surgical asepsis. We may be very proficient in practicing perfect technic (the "how"), but do we always know "why?" The reasons "why" must include the safety of the patient. Telling students "why" then, is one of the first ways to make a course patient-centered.

Other examples are:

(1) When teaching the care, use, and cost of instruments, point out their values in terms of (a) the effect of a poorly working instrument on the tissue of a patient, (b) the possible danger to the patient's life if a hemostat, for instance, will not hold on a major bleeding vessel, and (c) the high cost of repairing or replacing instruments which have been used for purposes not intended. This cost invariably is reflected in higher costs to the patient.

(2) Recognize the value of a friendly gesture or smile to the patient waiting to be anesthetized. The conduct of operating-room personnel is noticed and many times never forgotten by the patient about to undergo surgery.

(3) In the class on the positioning of the patient on the operating table, keep in mind that it is commendable to place the patient in perfect position for the surgeon, but is the patient comfortable and safe? How can he be placed so that the surgeon is able to do his best work and the patient is least likely to develop pressure sores and impaired nerve function?

These are just a few of the ways in which the same important course content can be taught so that it includes the reasons for doing things in certain ways. The program need not be any longer, since it merely requires a shift in emphasis from the cold approach of focusing attention on *how* to perform a technic to the warmer approach of telling *why* it is necessary.

Q. To whom should the clinical instructor be responsible: the operating room supervisor or the educational director?

A. Actually she is responsible to both. The clinical instructor and operating room supervisor have certain dual responsibilities; they are both responsible for the care of the patient and for the instruction of the staff. To what extent each carries out these functions depends upon the particular situation. Nevertheless, to function effectively, they must have a close working relationship.

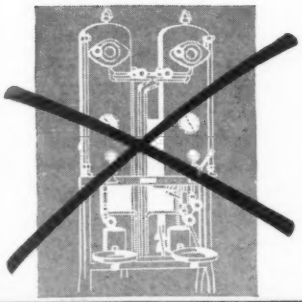
One must know the responsibilities, objectives, problems, and plans of the other; otherwise there are apt to be misunderstandings, false assumptions, and visual evidences of one camp set up against the other, instead of a team working together. To achieve such a close relationship, there must be informal daily exchange of pertinent information and the more formal weekly or bimonthly conference in which goals, plans, and other data are exchanged.

Naturally the clinical instructor is responsible to the educational director or director of nursing education, whereas the operating room supervisor is responsible to the director of nursing service. Even at these top-level positions, there must be an exchange of information if smooth working relations are to exist from the top down.

Q. How long should a course in operating-room nursing be, and who should plan it?

A. This varies with the quality of supervision. A four-week course in one school may be more effective than an eight-week experience in another school. The num-

(Continued on page 123)



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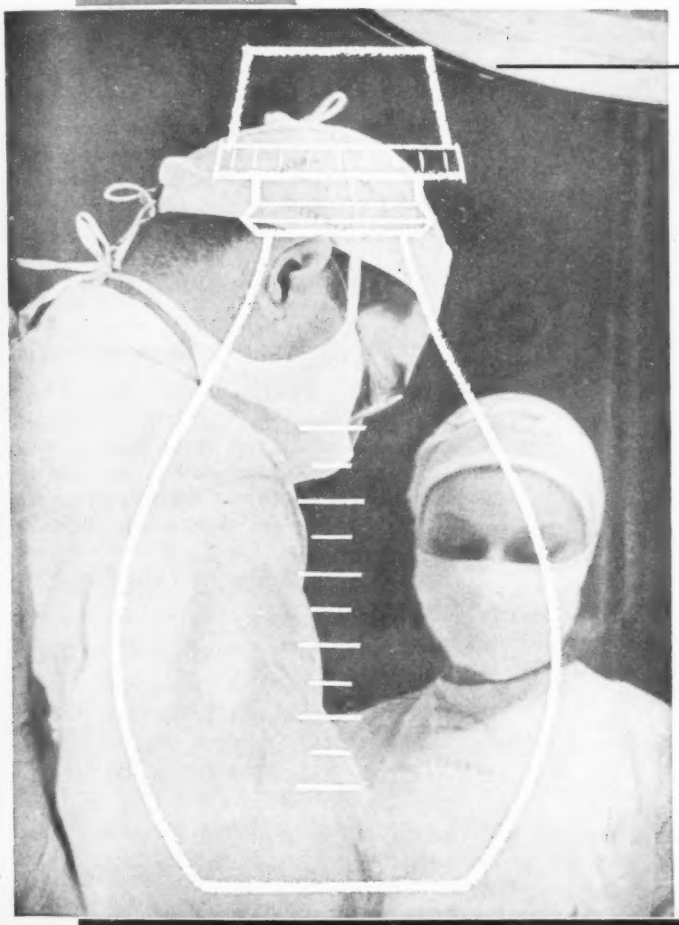

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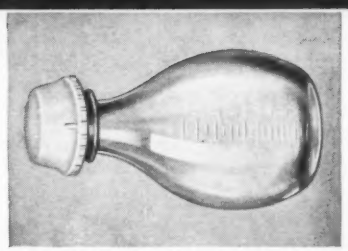

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O.R. PROBLEM CLINIC

(*Continued from page 120*)

ber of hours varies with quality of instruction. Usually the minimum is set by the state requirements. Beyond this minimum, the length of the course can vary.

Such a program must be planned with other interested members of the faculty and not by the instructor alone. The group would include the instructors in fundamentals of nursing, surgical nursing, the basic sciences, and perhaps emergency nursing and obstetrics. Obviously, the educational director would assist in such planning, and perhaps a senior student nurse. Needless to say, such a program cannot be planned in one meeting or even in one year.

Q. Cannot all the content usually given in the operating-room teaching program be given in other experiences of the student nurse?

A. Yes, content, as such, can be given elsewhere in the experience of the student nurse, to a lesser degree. The strength of teaching and the achievement of many of the objectives usually relegated to operating-room nursing result from the *greater* degree of emphasis which can be given in this program. Because it is more vivid and more concentrated, it seems logical to expect a higher and deeper extent of learning to take place.

Naturally this presupposes a suitable learning climate from the point of view of principles of psychology and learning. A student will not learn as well in a situation in which she is afraid or emotionally unprepared, in which there is inadequate time for practice, or she is expected to perform without previous instruction or proper supervision.

Q. Is there a trend toward eliminating operating-room nursing in the basic curriculum for professional student nurses?

A. If there is such a trend, I have not been aware of it. If it exists, the very core of basic surgical nursing is being attacked. The effective nursing care of a surgical patient cannot be learned if the student (1) is not able to observe what the surgeon does to correct or alleviate the problem of the surgical patient; (2) cannot understand and apply the principles of surgical asepsis where they are practiced in their fullest sense; (3) does not recognize the value of emotional stability and mental alertness, particularly in a tense or emergency situation, and (4) does not learn to work effectively on a team in which every member is necessary and the element of time is a precious one.

This experience is important not only to enable the student to care for the surgical patient more intelligently, but also for the invaluable preparation it gives the professional nurse in the event of natural or wartime disaster.

Q. Is it beneath the dignity of the modern student nurse to scrub instruments?

A. It is not beneath her dignity. However, it would seem a waste of her time and energy to be required to do this if nonprofessional or mechanical assistance were available, *provided* she could demonstrate the following:

(1) An understanding of how to clean the various kinds of instruments.

(2) Knowledge of the effect of chemicals, abrasives, washer-sterilizers, and ultrasonic cleaning on instruments.

(3) Ability to teach and supervise others in the cleaning and care of instruments.

Austenal Tells Plans For AORN Contest

A series of awards is being planned by Austenal, Inc., to help operating-room personnel attend the sixth national congress of the Association of Operating Room Nurses. The congress will be held at the Shamrock-Hilton Hotel, Houston, Tex., February 9-12, 1959.

Further details on the Austenal "appreciation awards" will appear in an early issue of HOSPITAL TOPICS.

To All National AORN Members Not Affiliated with a Unit

Elections for the following offices will be held at the next annual congress of the Association of Operating Room Nurses, in Houston, February 9-12, 1959:

President

Treasurer

Three board members

Three nominating committee members.

A nominee for any of these offices must have the following qualifications:

1. She must have been a national AORN member in 1957, and must be a member in good standing for the current year.

2. She must be a member of the American Nurses' Association.

3. She must have held one term of office in a local AORN group.

4. She must be certain of her availability for national board meetings.

A biographical sketch of each nominee should be submitted. Photographs must be submitted if the nominee is selected for the ballot.

Every national AORN member not affiliated with a local unit is invited to submit one name for each of the offices mentioned, along with a biographical sketch of each person.

In order that every nominee may be given due consideration, the names should be submitted to the chairman of the national nominating committee no later than October 1, 1958.

Mrs. Doris Deimel, R.N., Chairman
National Nominating Committee
Association of Operating Room Nurses
32 Hampshire Road
Rockville Centre, N.Y.

SELECTED BIBLIOGRAPHY

(*Continued from page 117*)

solutions before handling or use, to avoid severe dermatitis in personnel and severe tissue reactions in patients.

(*ED. NOTE: No mention is made in this study of the effect of any of the agents on lens cement or conducting systems.*)

Chiara, Nicholas: "A New Lotion for Newborn Skin Cleansing." *N. Y. State J. Med.* 57:2391, July 15, 1957.

Even with meticulous nursery technics, nonspecific rashes in the newborn may reach as high as 25 percent. Methods of skin care range from a "no bath" technic through soap and water, oil and antiseptic lotion. The "no bath" technic is apparently the best from the point of view of saving the newborn's skin but the least acceptable from an esthetic point of view. In this study, contraindications to the use of soap and oil are discussed as well as the advantages of antiseptic lotions.

A product containing methylbenzethonium chloride (Diaparene) was studied on a series of newborn. One group was cleaned with mineral oil; the second with a hexachlorophene lotion, and the third with the quaternary ammonium lotion. The infants were studied for six days after birth. Rashes occurred in 21.4 with oil; in 10.3 with the hexachlorophene lotion, and in 5.9 with the quaternary ammonium lotion.

No irritation or sensitivity was noted after use of the lotion. The authors conjecture that one reason for the success with this treatment may be the presence in the lotion of magnesium citrate, which promotes normal skin respiration, in itself a major factor in the prevention of skin rashes.

Current Comments and Case Reports: Reaction to Improperly Cleaned Endotracheal Catheters. *Anesthesiology* 18:505, May-June, 1957.

A normal 20-year-old woman with pulmonary tuberculosis, prepared with routine medication for lobectomy, developed severe bronchospasm in the left lung after routine induction and positioning in the left lateral position. Numerous rhonchi and rales were heard throughout the left lung, and the right lung was overdistended. Bronchospasm and hypotension persisted throughout the four-hour procedure. There was little response to atropine and methoxamine. At the end of the procedure the patient had respiratory difficulty, and frothy fluid was aspirated from the lung.

Artificial respiration with oxygen was started, and four hours after surgery the patient had apparently recovered from her distress. She no longer coughed up froth, and the rhonchi and rales had disappeared. In the course of investigating the events leading up to this patient's difficulty, it was discovered that the endotracheal tube had been disinfected in paraformaldehyde and had not been rinsed after disinfection. It was concluded that residual formaldehyde in the tube mixed with secretions which gravitated into the dependent lung and was sufficient to cause bronchoconstriction, flooding of the trachea and bronchi by fluid, and circulatory depression.

Control of Supplies

By Arlene Howe, R.N.*

• In today's hospital, the central service department has emerged as an indispensable department in the maintenance and improvement of patient care. Its importance has increased as administration and nursing have realized the assistance it can give in terms of service to nursing units, operating rooms, delivery suites, and other service departments.

Any planned co-ordination of effort that (1) increases productivity, (2) provides for better utilization of manpower, (3) leads toward more economical operation, (4) decreases time lapse between need and availability, and (5) develops a better understanding of responsibilities *should* lead to better patient care. We in central service should have this as our goal.

Centralization in central service of various functions formerly performed by nursing personnel has meant substantial expansion in the department's activities. Expansion has resulted in an increase in the expense of operating the department.

The central service department is a rapidly growing addition to hospital administration, and by merit will receive more and more attention in the future. A relatively standardized system of records will enable central services to compare results and efficiency.

Experience has made it evident that any department will do better if it has an adequate number of records to show who has what, what to anticipate in regard to supplies, and figures with which it is possible to go before administration to justify changes and the need for new equipment.

Hospital personnel all the way from the governing board to the aide have become "cost-conscious." Many hospitals have established commodity budgets within their various departments; some hospitals have established individual nursing unit commodity budgets.

With a concentration of medical and surgical expense in central service has come the problem of apportioning the department's cost to the various other units and departments that use its services. In hospitals which have such accounting practices it is imperative that records be kept of items charged to individual unit budgets.

In most hospitals some direct charges to patients are made by the central service department. Records must be kept to make such charges.

But regardless of any forces outside the department, a control system is necessary for the efficient operation of the central service department itself.

What do we mean by control? Webster defines control as:

(1) To check or regulate; to keep within limits.

(2) To test or verify by counter or parallel evidence of experiment.

(3) Reserve or restraint.

(4) Anything affording a standard of comparison or means of verification; a check.

A control system is necessary to central service because it results in a standard for comparison and serves as a means of verification.

Forms and records are essential to issue, expedite, and account for distribution of items. Records are used to obtain and maintain control. They may vary as the situation demands, but they should be simple and easy to maintain, and should be kept to a minimum. They should be of such a nature that it does not take a specialized person to keep them.

Different methods of control are required to meet these different needs:

(1) The need to maintain supplies for processing in central service.

(2) The need to maintain sterile supplies for distribution to individual units.

(3) The need to maintain supplies within the individual unit.

(4) The need to know who has what, and where.

Different hospitals have different systems for purchasing and storing materials processed in the central service department. If supplies are maintained by a separate department such as the storeroom, the amount of supplies maintained in central service for processing can be far less than in the central service department which must also act as a storeroom for the entire hospital.

For those central service departments acting as storerooms, maintaining a perpetual inventory is of great value. The perpetual inventory can be kept on Kardex cards, each carrying all information regarding specifications of the item, as well as the cost, the number received, the number issued, and amount of stock remaining. Even though there is a storeroom which maintains a perpetual inventory of most materials used in the depart-

*Nurse consultant, research department, American Sterilizer Co., Erie, Pa. This article is adapted from a lecture given at a symposium on professional hospital technics and procedures, presented at the Boston City College (see pages 23 and 24 of the May issue).

ment, this system might well be adopted for those special purchases which invariably exist.

Or, records for maintaining both sterile and unsterile supplies within the central service department might well be incorporated into one form. This can also serve as a guide for location of items. The item is listed; in one column is indicated the numbers of the cabinet and of the shelf on which the unsterile item is stored; in a second column is listed the standard quantity of unsterile item to be kept on hand. In other columns the location and standard quantities of the unsterile item are indicated (Figure 1, page 126).

Cabinets can easily be checked for needs by any classification of worker in central service, and appropriate requisitions written at this time. Other activities can be incorporated with this function, from cleaning the shelf to checking for length of sterility.

A properly controlled inventory, based on maximum usage, will aid in assuring an adequate amount of materials available without having excess supplies which will become outdated. In many hospitals, checking for outdated items is more often needed than checking in order to maintain adequate supplies.

The person issuing supplies throughout the day also can endeavor to keep those responsible for maintaining supplies informed of the approximate use, such as tray sets, so that they may be readily replaced.

The method of distribution to the individual unit has a direct bearing on the type of control adopted for maintaining supplies within the individual unit. An important factor is keeping the time limit between need and availability at a minimum. In many instances, the method of distribution which offers the best service to individual units is the method most conducive to accurate records for central service. Perhaps this is the reason that the quota or standard quantity system is practical.

When we discuss method of distribution to individual units, it becomes necessary to break down into various classifications the items furnished by central service. For instance, we know that a hypodermic needle does not merit the same type of control as a tracheotomy tray.

Central service items may be classified as follows:

(1) Supplies used and not returned to the department, such as dressings and all expendable items, either sterile or unsterile.

(2) Supplies used in quantities and returned to central service for processing, such as needles, syringes, gloves, and instrument sets.

(3) Sterile and unsterile items used for specific patients, such as therapeutic tray sets and suction machines.

Effective control of inventory or standards of quality, which includes proper rotation of supplies to insure a controlled length of sterility, is impossible when more than one organization or department is charged with the same duties. We all know that frequently requisitions are written on nursing units without any check of standard quantities. And how can we be assured that there is rotation of supplies when it is not the specific assignment of any individual? In hospitals in which it was believed the best of controls were exercised, sterile supplies have been found to be as outdated as one year.

It is recommended, therefore, that distribution and storage areas within the individual unit for supplies obtained from central service be the responsibility of central service personnel, particularly for those items whose quality is of primary concern.

The amount of expendable supplies, both sterile and unsterile, maintained on each unit will depend largely on need and available storage space. Standard quantities should be established. A one-day supply should be the minimum amount maintained, and the supply should be replenished at specific intervals.

REUSABLE SUPPLES

Delivery of supplies used in quantities and returned to central service for processing, such as needles, syringes, gloves, dressing instruments, and frequently-used treat-

(*Continued on next page*)

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- protect your investment in wall finishes, woodwork and furnishings.

Tough, resilient, smudge-proof, they simply slip around each leg of any hospital bed. Bolt and nut embedded in the specially compounded rubber fasten them in place quickly and easily. Small in cost, they start paying for themselves the day you install them!

Standard 5" outside diameter affords all-round protection. Select type and inside size from these convenient diagrams:

ROUND POST Sizes: 1", 1¼", 1½", 2"

SQUARE POST Sizes: 1¼", 1½", 2"

GRACELINE POST Size: 1⅞" x 1⅝"

All in rich walnut color.

Lots of 6 doz. ..... $20.50 doz.
Lots of 3 doz. ..... 21.55 doz.
Smaller lots ..... 22.40 doz.

Prices in larger quantities on request

Meinecke & COMPANY, INC.

65 years of continuous service to the hospitals of America

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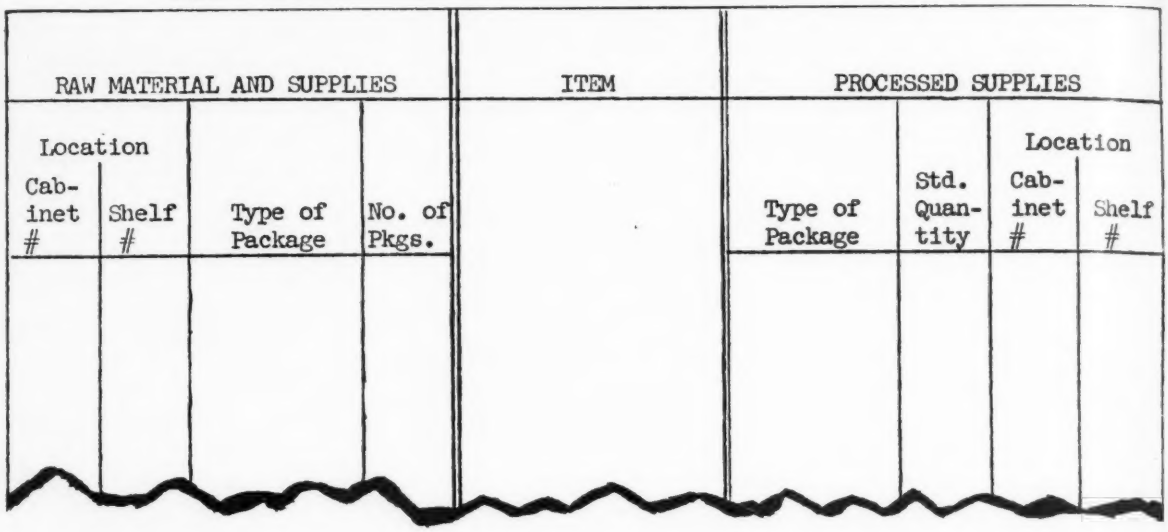
Figure 1. Form for maintaining records of sterile and unsterile items in central service department.



CENTRAL SUPPLY continued

ment trays, is more effective when handled in the same manner as delivery of expendable items. Standards can be established and maintained by the central service department.

There should be an adequate amount of supplies to offer efficient care to patients for a specified period of time, but not such quantities that reprocessing of outdated items becomes a major task.

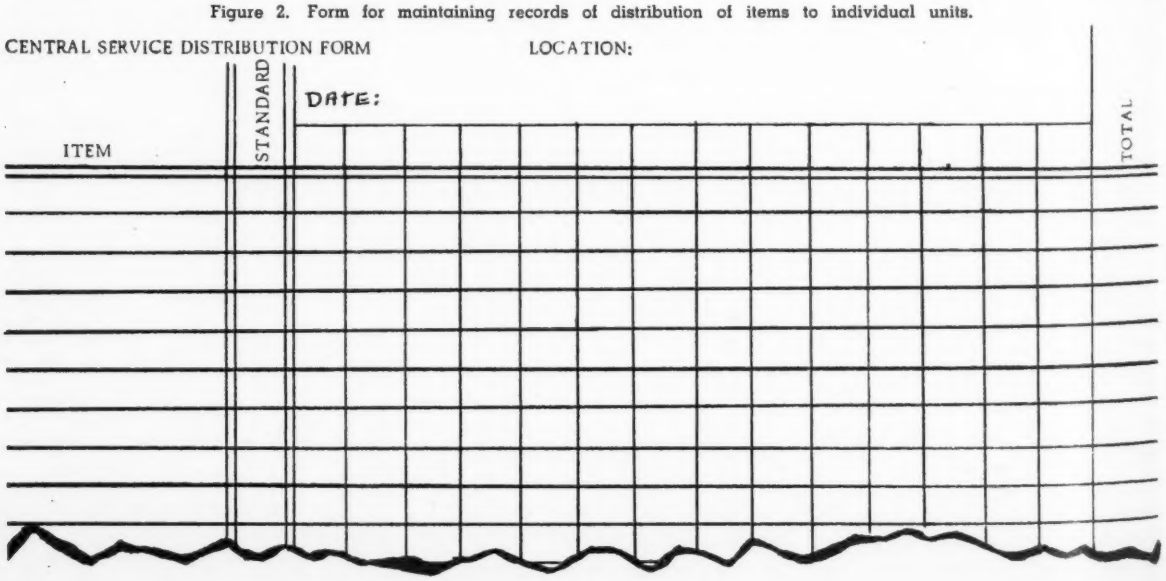
Delivery of such items is preferably done once a day. This specifically applies to those items processed on a mass-production basis, such as needles, syringes, gloves, catheters, irrigating sets and basins, drainage bottles, and perhaps enema and catheterization trays. The delivery schedule adopted has a very important relationship to the grouping of activities in the central service department.

Let us take, for example, the processing of syringes, needles, and gloves. By grouping these major departmental activities into "one-time-a-day" activities, we can produce the processed items more economically and without confusion. We eliminate the many "get ready" and "put away" times, and workers can become more proficient at actually doing the task.

A point which must be emphasized is that adequate materials must be maintained in circulation to insure fulfillment of the individual unit needs, regardless of the type of delivery service established. A major obstacle to maintaining a smooth flow of materials, in the processing procedure within the central service department and of processed items between central service and the individual unit, is an inadequate amount of supplies in circulation.

How many times have we had to wait for linen items from the laundry before we could finish our sterile packs or choose certain floors to "short" because we were out of such

Figure 2. Form for maintaining records of distribution of items to individual units.



items as syringes or irrigating sets?

We should analyze carefully the amounts needed. For example, we are agreed that we should maintain a minimum of four times and preferably five times the maximum amount of daily linen needs in circulation—one being used, one being washed in the laundry, one being processed in the central service department, and one in transit between these areas.

Consideration should be given to all facets of a process to insure that proper precautions are being exercised to assure maximum economy. An additional day's supply of gloves should be in circulation so that proper storage practices can be carried out. Again, five times the maximum daily needs are recommended —one in use, one being washed and dried, one being tested, packaged and sterilized, one being held aside to regain tensile strength, and one in transit.

If items do not go to other departments for any part of the processing or if no extra precautions are necessary, a two-day supply should be sufficient to maintain an even work flow.

We should keep in mind that one goal of the central service department is to decrease the time lapse between need and availability and to make better utilization of manpower. Delivery of specific items should be co-ordinated with need and usage. Maintaining an adequate supply of materials within the unit to offer effective patient care will discourage hoarding.

Once the supervisor has gained the confidence of the various departments that she can and will furnish materials normally processed in central service as the need arises, hoarding will cease.

Standardized storage areas within each nursing unit are invaluable for such a delivery service. A well-stocked delivery cart, adequate in size but easily moved, is a must.

Records should be maintained of quantities left on the unit at each delivery (Figure 2). They will show the amount used by the individual unit and, if charges are made to the unit, they may also serve as a record for such charges. The desired standard quantities for various items can be arrived at very quickly from a review of these figures. Standard quantities may have to be changed from time to time according to needs.

Delivery of sterile and unsterile items used for specific patients can become a problem if there is no dumb-waiter service. Some central services are offering hourly delivery and pickup of such items.

Is this practical? Let's suppose that the department is offering service to 10 nursing units. Which is best, to assign one person from the central service department to make rounds to these units in an organized manner, or to have personnel from each of the 10 nursing units returning and picking up items at random—a system which requires the time of a person at the dispensing and receiving location? Regular deliveries also decrease the number of so-called "emergency deliveries."

An effective delivery service for requested items should be a part of the services rendered by the central service department, providing there is no other messenger service available. The frequency of such deliveries will be influenced by the types and amounts of items maintained in standard quantities on the individual unit.

Pickup of soiled items is as important as delivery in contributing to an efficient and safe operation. Many hospitals follow the practice of "even exchange," the exchange of a soiled item for a clean item. Frequently the delivery cart carries both soiled and clean items, and workers are simultaneously handling clean and soiled items without practicing proper handwashing technics, because there is neither the time nor the facilities.

What better way is there to spread the dreaded staphylococci or other contamination throughout the hospital? And what actual use is made of information collected on this exchange basis? In many hospitals, it is not recorded.

(*Continued on next page*)

DIACK

SINCE 1909

Sterilization Today but Not Tomorrow

Learn how to wrap your dressings loosely, how to pack them into the autoclave chamber properly and to watch all the gauges and instruments during the sterilization. It will give you sterile dressings today.

But tomorrow when someone else runs the autoclave, little Diacks will stand by to help you supervise someone else's sterilization techniques. Will she be as careful as you are?

Diack Controls are for people who know that sterilization is only as perfect as the person who runs the autoclave —that Diack Controls check that slip-up which is bound to occur.

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(Sole Manufacturers of Diack Controls and Inform Controls)

Royal Oak, Michigan

A specific area within each nursing unit should be designated for the collection of soiled items, and of course an area should be designated for receiving processed items from central service. This principle of separation of clean and soiled items should also be kept in mind when using dumbwaiters for transportation of these items.

How does the department keep from losing items if there is no even exchange? Remember that two of the goals of the central service department are better utilization of manpower and more economical operation. These criteria should guide the supervisor in establishing her policies. The time spent in accounting for a lost hypodermic needle would soon far outweigh any savings derived.

The physical setup should be conducive to the return of items by providing a conveniently located specified area for the collection of soiled items. Co-operation of the staff in returning items to the specified area immediately following use is a vital factor in the control of losses.

The frequent delivery and pickup service is a great aid in the control of missing items. When used trays, for example, are returned promptly to the specified area and picked up promptly, there is quick recognition of missing items. Immediate followups may require only a moment, and they produce good results.

The delivery person is one of the department's greatest public relations officers. She should be well informed of her responsibilities and the reason that these activities should be carried out. She must be tactful.

It is very helpful if the central service supervisor takes the time occasionally to go out with the delivery person. If the supervisor shows the various departments that she is interested in their problems, it is amazing how easily she can correct many problems once she recognizes they exist.

Any control system adopted must meet the needs of the particular hospital and fit into the structure of operation. The method of control should be discussed with the hospital administration and other persons in authority. A successful control system must have their backing.

Whatever procedure is finally agreed upon, with the special policies and limitations established, it is of supreme importance that the personnel of all departments involved, including the central service department, be fully aware of what is being done. They should be made to understand that checking is a business procedure and is not done solely because of distrust. The rules and regulations exist for only one reason—the welfare of the patient. Make this an inspiration for all. Appeal to their integrity.

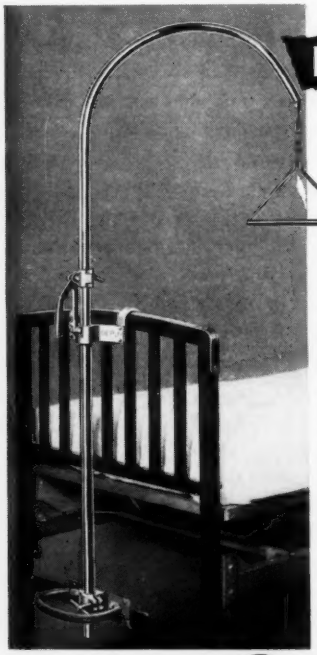
Factual reporting helps to determine where losses occur. Get these facts from the department's records. Report missing items promptly to those in command, so that an investigation can be carried out if desired. Records will soon indicate whether missing items are being carelessly mislaid somewhere or whether pilferage is a problem.

It takes a mature adult approach to do the job at hand. Until the hospital accepts its problems, little progress can be made.

SUMMARY

Maintenance of records, establishment of a good delivery and pickup service with assigned space for each activity, formulation of policies and education of personnel to understand these policies, adherence to standard practices, and support from administration are all necessary for the proper control of supplies.

The hospital and its staff must have confidence in the control system, and feel that it is for better and more economical patient care. Once rapport is established, full co-operation can be obtained in all areas.



IMPROVED PATIENT HELPER

by DePuy

This unit combines the popular goose-neck style patient helper with our exclusive lock-lever bed clamps. One nurse can attach the Improved Patient Helper in rigid position to practically any style hospital bed in a few moments. The rubber padded clamps attach to any head or foot portion of bed . . . no corner post attachment. Goose-neck fits down into supporting tube for greater strength. All tubing nickel plated electric welded steel. Trapeze portion swings free . . . can be swung out of way when not in use. A valuable patient aid . . . helps patient help himself! No. 670.

NEW WALL PROTECTOR

Prevents clamps of the Improved Patient Helper, Featherwight Overhead Frame, or Crib Fracture Set from damaging walls. Rubber covered steel. Easily attached to any of the above units. No. 675.

DePuy MANUFACTURING CO., INC.

Since 1895 Standard of Quality

WARSAW • INDIANA

PERSONALLY SPEAKING

(*Continued from page 73*)

Daniel M. Widmer — has been named office manager, Salem (Ore.) General Hospital. He was formerly office manager, Valley View Hospital, Glenwood Springs, Colo.

John R. Willis—has been named purchasing agent, Rex Hospital, Raleigh, N.C., replacing **Winnie Cash.** Mr. Willis recently completed a preceptorship in hospital administration at the hospital.

VA Appointments

T. L. Harvey, M.D.—has become manager, VA Hospital, New Orleans. He was previously manager of the Montgomery, Ala., VA Hospital.

R. W. Hipsley, M.D.—formerly manager, New Orleans VA Hospital, has been appointed manager, VA Hospital, Butler, Pa.

William W. Leak—formerly assistant manager, VA Hospital, Augusta, Ga., has been named manager of the Muskogee, Okla., VA Hospital.

Daniel H. Miller, M.D.—has been appointed manager, VA Hospital, Montgomery, Ala. Prior to transfer he was manager, VA Hospital, Muskogee, Okla.

Benjamin B. Wells, M.D.—director of professional services, VA Hospital, New Orleans, has been appointed director, medical education services, VA Department of Medicine and Surgery, Washington, D.C.

VA Nursing Appointments

William Beha—has become assistant chief, nursing education, VA Hospital, Houston, Tex. He was previously an instructor at the Oteen, N.C., VA Hospital.

Catherine Bray—is chief, nursing service, Montrose, N.Y., VA Hospital. Prior to transfer she held a similar position at the Downey, Ill., VA Hospital.

Florence Cohen—has been named chief, nursing unit, Philadelphia Regional Office VA Clinic. She previously held a similar position at Dallas, Tex.

Ruth Ann Foster—has been transferred to the Fort Bayard, N. Mex., VA Hospital as chief, nursing service. She had been assistant chief, nursing service, VA Hospital, Sepulveda, Calif.

Blanche Grosscup—is chief, nursing service, Amarillo, Tex., VA Hospital. Previously she held a similar position at the VA Hospital, Huntington, W. Va.

Reva Haskins—is now chief, nursing service, Wadsworth division, VA Hospital, Los Angeles. Prior to transfer she held a similar position at the Syracuse, N.Y., VA Hospital.

Gwendolyn Hussey — has been named supervisor, outpatient service, VA Hospital, Dallas, Tex. Previously she was chief, nursing unit, Philadelphia Regional Office VA Clinic.

New Officers

Charles T. Treadway, Jr., president, Bristol (Conn.) Hospital, was named president-elect of the Connecticut Hospital Association at its 40th annual meeting, held in June. **Robert C. Kniffen,** managing director, New Britain (Conn.) General Hospital, was installed as president.

Albert L. Boulenger, administrator, Good Samaritan Hospital, Vincennes, Ind., has been named president-elect of the Indiana Hospital Association by the group's board of directors. He succeeds **Emery K. Zimmerman,** administrator, Elkhart (Ind.) General Hospital, who resigned from the position because of ill health. Mr. Boulenger was formerly vice-president of the association.

Deaths

Graham L. Davis, M.D.—65, administrator, Onslow County Memorial Hospital, Jacksonville, N.C., died July 5.

A past president of the American Hospital Association, Mr. Davis was a widely-known consultant and administrator.

He was director of the division of hospitals of the W. K. Kellogg Foundation, Battle Creek, Mich., from 1940 to 1951, and served as director of the National Commission on Financing Hospital Care from 1951 to 1953.

He was a member of the American Hospital Association, American Association of Hospital Consultants, and was president of the American Medical Association in 1947.

John F. Lewis, M.D.—71, former chief medical officer, VA Hospital, Philadelphia, died April 22. He had served the Philadelphia hospital from 1945 until his retirement in 1957.

Murray Schnee—55, purchasing executive, Montefiore Hospital, New York City, died June 28. He had been a member of the hospital staff for almost 35 years and was the author of *Stock-a-Log*, describing a purchasing system for institutions.

Students Appointed To Residencies

Appointments to administrative residencies for students who have completed academic work at Northwestern University, Chicago, are as follows: William J. Allen to Raymond C. Wilson, administrator, Southern Baptist Hospital, New Orleans; Don Lee Arnwine to Robert L. Denholm, director, University of Colorado General Hospital, Denver; Robert Aronno to Cecil G. Sheps, M.D., executive director, Beth Israel Hospital, Boston.

William F. Baker, Capt., USAF to Col. Julian Jarman and Maj. Kenneth Long, USAF Hospital, Maxwell Air Force Base, Montgomery, Ala; John P. Certo to Sister Mary Thomasine, administrator, St. Francis General Hospital and Rehabilitation Institute, Pittsburgh; James V. Dorsett, Jr. to Matthew F. McNulty, Jr., administrator, University Hospital and Hillman Clinic, Birmingham, Ala.

Selma N. Earle to Kermit H. Gates, M.D., executive director, Jackson Memorial Hospital, Miami, Fla.; Harry Eliazarian to Martin S. Ulan, administrator, Hackensack (N.J.) Hospital; Joseph L. Faletra to William S. Brines, director, Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Lt. John Frezza, USAF to Col. James W. Humphreys, Jr., and Capt. Berlow, USAF Hospital, Wright-Patterson Air Force Base, Dayton, O.

Frederick L. Gibson to Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif.; Robert

(*Continued on next page*)

F. Gilmore to Albin H. Oberg, executive director, Clara Maas Memorial Hospital, Belleville, N.J.; Karl D. Glunz to Sister Mary Jovita, administrator, St. Joseph's Hospital, Milwaukee, Wis.

William D. Hilliard to Vernon D. Seifert, administrator, Fairview Park Hospital, Cleveland, O.; Charles D. Holland to Gene Kidd, administrator, Baptist Hospital, Nashville, Tenn.; James R. Horton to Thomas W. Fourqurean, administrator, Brackenridge Hospital, Austin, Tex.; Robert E. Huesers to Robert F. Brown, M.D., director, Doctor's Hospital, Seattle, Wash.; George W. Jackson to Lee D. Cady, M.D., manager, VA Hospital, Houston, Tex.

Rolin H. Johnson to Robert M. Jones, administrator, Waukesha (Wis.) Memorial Hospital; Jerome M. Kasdan to Nathan W. Helman, director, Mount Sinai Hospital, Chicago; Roland E. Kohr to Lawrence Brett, superintendent, Bethesda Hospital, Cincinnati, O.; Gerald M. Krantz to James M. Dunlop, administrator, Bridgeport (Conn.) Hospital.

Raymond W. Leitner to Paul R. Hanson, administrator, Emanuel Hospital, Portland, Ore.; Louis J. Lonni to Herbert R. Rodde, administrator, Highland Park (Ill.) Hospital Foundation; Melvin A. Lyons to Bob Byrne, administrator, Providence Memorial Hospital, El Paso, Tex.; John C. McGreevy to J. L. MacFarland, administrator, Harrisburg (Pa.) Polyclinic.

George P. Mancuso to Norman D. Bailey, executive director, Grant Hospital, Chicago; Peter R. Mariani to W. C. McLin, administrator, Community Hospital of Indianapolis, Ind.; Herbert P. Neef to Paul W. Kempe, superintendent, Silver Cross Hospital, Joliet, Ill.; Edward L. Olson to Nils G. Axelson, administrator, Swedish Covenant Hospital, Chicago.

Morris H. Parrish to W. Wilson Turner, administrator, Memorial Hospital, Houston, Tex.; Frank Puntenney, Jr. to Jack Zubor, administrator, Columbus (O.) State Hospital; Leo Reich to Arkell B. Cook, director, Butterworth Hospital, Grand Rapids, Mich.; James C. Ruthrauff to Roy C. House, superintendent, Wesley Hospital, Wichita, Kan.

Jack L. Samuels to Abel D. Swirsky, administrator, Mount Sinai Hospital, Milwaukee, Wis.; Joseph A. Saunders to George E. Peale, superintendent, California Hospital, Los Angeles; John H. Schill to Pat N. Groner, administrator, Baptist Hospital, Pensacola, Fla.; James F. Shepherd to Victor D. Bjork, administrator, Flower Hospital, Toledo, O.; John Lee Stellner to Lawrence Payne, administrator, Baptist Memorial Hospital, Jacksonville, Fla.

John H. Stocking to Harold C. Mickey, administrator, Rochester (Minn.) Methodist Hospital; Robert A. Tittle to David R. Kenerson, administrator, Mound Park Hospital, St. Petersburg, Fla.; Alan H. Toppel to Ralph M. Hueston, superintendent, Chicago (Ill.) Wesley Memorial Hospital; Lloyd J. Verret to Edward H. Leveroos, M.D., director, Ochsner Foundation Hospital, New Orleans.

Richard M. Warren to Harold L. Peterson, administrator, Baroness Erlanger Hospital, Chattanooga, Tenn.; Cyril H. Weagle, Jr. to Edgar O. Mansfield, superintendent, White Cross Hospital, Columbus, O.; Roger W. Weseli to Sister Eugene Marie, administrator, Good Samaritan Hospital, Cincinnati, O.; Ronald H. Wilson to Norman H. Wiley, M.D., superintendent, Gorgas Hospital, Balboa Heights, Canal Zone; Mark E. Wittock to Dan Macer, manager, VA Research Hospital, Chicago.

MISS PHOEBE NO. 24 IN A SERIES

"I'd never dare go in that field myself—but then *I* don't have an Everest & Jennings chair."

E J

Everest & Jennings folding wheel chairs don't *really* behave like magic carpets. Their superb maneuverability, lightness and balance just make it *seem* that way. Equally astonishing to the hospital that buys them is the enduring, maintenance-free ruggedness that makes Everest & Jennings chairs a bigger bargain every year.

Specify **EVEREST & JENNINGS** chairs for your hospital

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TRADE TOPICS . . .

Warner-Lambert Forms Research Institute

L. Earle Arnow, M.D., has been appointed to head the newly-formed Warner-Lambert Research Institute.

Dr. Arnow, former executive director, Merck Sharp & Dohme Institute for Therapeutic Research, will be responsible for administering research in the various divisions of Warner-Lambert Pharmaceutical Co.

Norwich Builds New Plants

Norwich Pharmacal Co. has begun a $1,000,000 expansion program of its manufacturing facilities. Construction is underway on a series of buildings to house the equipment for producing Furoxone and Furadantin.

Construction is also beginning on a series of buildings which will enable the company's other drugs to be manufactured in separate units rather than in one central chemical plant as is now done.

Diversey Corp. Elects New Vice-president

Eric Foote, assistant to the president, Diversey Corp., has been elected vice-president in charge of manufacturing operations in the U. S. Mr. Foote, who has been with the firm for 11 years, is one of the youngest executives in the history of the company. He will supervise operations in seven plants.

Volk Radiochemical Co. Has Expansion Program

Additional personnel and facilities have been added to Volk Radiochemical, enabling the company to provide all the proved radiopharmaceuticals, as well as to cooperate with medical researchers in the development of new uses for radioisotopes. The company previously manufactured a limited number of medical products.

At recent medical sales refresher conference held by the Ritter Co. for its dealers in the San Francisco area, Lew Cook, district representative in San Francisco, demonstrates Ritter and Liebel-Flarsheim equipment. Conference, held June 20-21, immediately prior to the American Medical Association convention, was repeated a week later in Los Angeles for dealers in that area. Other members of faculty, besides Mr. Cook, were C. G. Sanderson, manager, special services, and Joe Marsh, sales manager, both of Ritter's medical-hospital division, in Rochester, N.Y.; Harry Mortimer, Los Angeles, Paul Hanafin, Kansas City, and Herman Medler, Washington, D.C., all district representatives; and A. R. Kelly, Los Angeles, special representative.

Leonard Walker, Ph.D., has been appointed to the new position of director of the radiomedical department. He was formerly director of research for Nuclear Consultants.

New Appointments Made At Purdue Frederick Co.

S. J. London, M.D., has been appointed medical director, The Purdue Frederick Co., to supervise pharmacological research and development of new drugs. He was previously instructor in medicine, Wayne State University College of Medicine, Detroit.

Named as associate medical director, to head the newly created division of clinical investigation is H. S. Tirsch, M.D., who has been associated with the firm since 1956.

The same company has elected Seymour A. Lubman, formerly director of sales, as vice-president in charge of sales; and has promoted Murray Altman to director of sales training, and Marvin Weinberg to assistant to the vice-president in charge of sales.

DePuy Vice-president Retires After 52 Years

DePuy Manufacturing Co. has announced the retirement of Earl E. Longfellow after 52 years of continuous service. Joining the company in 1906, when it was the first metal splint manufacturing concern in the world, Mr. Longfellow moved from errand boy to vice-president and general manager, and was long a guiding force in the orthopedic appliance field.

Medical Director Named By G. F. Harvey Co.

Martin C. Sampson, M.D., has been appointed medical director, G. F. Harvey Co., to head the pharmacological and clinical research on new drugs developed in the company's laboratories. Dr. Sampson was formerly with the research and development division, Smith, Kline & French Laboratories.

(*Continued on next page*)

Wyeth Announces Pediatrics Grants

Names of 20 recipients of the first annual Wyeth Laboratories pediatric residency fellowships were announced by Philip S. Barba, M.D., past president of the American Academy of Pediatrics, and chairman of the selection committee.

Each M.D. will receive a grant of $4,800, providing for a two-year postgraduate course in pediatrics. Named were:

S. Wayne Klein, Baltimore; Robert B. Cole, Cleveland, O.; Floy C. Helwig, Baltimore; Warren D. Grover, Camp LeJeune, N.C.; Luther B. Travis, Fort Benning, Ga.; John D. Siegfried, Red Lake, Minn.; George T. Kimbrough, Birmingham, Ala.; Donald E. Carey, New Orleans; Marvin L. Rallison, Minneapolis.

Also, Allan L. Drash, Baltimore; William G. Kenney, Rochester N.Y.; Paula Neyman, New York City; Keith Hammond, Paoli, Ind.;

Robert O. Hickman, Salt Lake City; John C. Gilliland, Jackson, Miss.; Jon L. Karlsson, Santa Rosa, Calif.; John I. Larkin, Albany, N.Y.; William A. Moon, Jr., Denver; George A. Lentz, Baltimore; and Paul J. Uhlig, Oceanside, Calif.

Sales representatives of Becton, Dickinson and Co. recently attended four regional sales meetings held in Washington, D. C. (above), Omaha, Neb., Highland Park, Ill., and Phoenix, Ariz. The Omaha meeting was devoted to the sales force while the others were held for the company's hospital-surgical representatives.

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Confidential listings (men and women) for administrators, personnel directors, business managers, dietitians, physicians, directors of nurses, therapists, pharmacists, medical record librarians, anesthetists, public relations directors, housekeepers, bacteriologists, biochemists, anesthetists, medical technologists, x-ray technicians, food service managers.

All inquiries are strictly confidential.

On our floor
WHAT ON EARTH IS THAT ?
IT'S THE IMPROVED R36 50cc. CONTROLLED VOLUME PEDIATRIC UNIT. . . NOW IT'S CALLED PEDATROL, AND EACH OF THESE SEGMENTS HOLDS EXACTLY 10ml.
AND WE THOUGHT THE OLD R36 WAS THE LAST WORD IN ACCURACY.
ACTUALLY IT WAS . . . UNTIL PEDATROL CAME ALONG WITH THIS SEGMENTED CHAMBER. YOU CAN SET ANY DOSAGE FROM 10ml. TO 50ml, SIMPLY BY CLAMPING BETWEEN THE COMPARTMENTS.

BAXTER LABORATORIES, INC. **Morton Grove, Illinois**

'Grand Rounds' Wins Ohio State TV Award

The closed-circuit network series "Grand Rounds" has won first place in the Ohio State University Awards for educational television.

Provided for the medical profession by The Upjohn Co., it won the award for programs directed to broad, special interest audiences.

Vice-president Joins Pacific Instruments Corp.

Lew Schroeder has been appointed vice-president and general sales manager, Pacific Instruments Corp.

Mr. Schroeder has 26 years' experience in the business machine field.

Wyeth Labs to Construct Research Laboratory

An ultra-modern laboratory will be constructed by Wyeth Laboratories adjacent to their Institute for Medical Research at Radnor, Pa.

Scheduled for completion next spring, the new facilities will enable Wyeth to increase its study of infectious diseases and expand its research in organic chemistry.

Lilly Executive Named HIF Board Chairman

The Health Information Foundation recently named Eugene N. Beesley, president, Eli Lilly and Co., chairman of its board of directors.

He succeeds George F. Smith, Johnson and Johnson president, who was elected a vice-president of the foundation at its ninth annual meeting.

News Briefs

Vincent B. Devine—has joined Conco Surgical Products, Inc., as assistant sales manager. He was formerly with The Seamless Rubber Co.

* * *

Elizabeth LeMay—is new editor of medical publications, Winthrop

(*Continued on next page*)

PROTECTION*

*Ident-A-Band is the *one* system that provides *sealed-on* protection—the system that *rivet-seals* all identifying data inside. And only Ident-A-Band gives this really permanent *sealed-on* and *sealed-in* protection... at a cost so reasonable that every hospital can easily afford it.

Ident-A-Band®

prevents mixups!

Free Ident-A-Band Samples – Complete information without obligation. Write –

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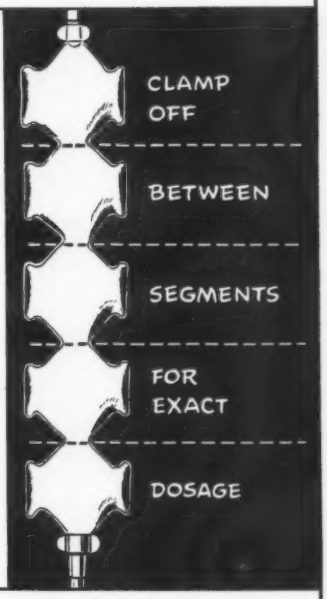
833 N. Orleans St., Chicago 10, Ill.

WELL I NEVER! CLAMP THE HEMOSTAT HERE AND THE PATIENT GETS 20ml. -NO MORE, NO LESS! SIMPLE ISN'T IT?
—AND YOU CAN BE CERTAIN OF COMPLETE SAFETY AND ACCURACY OF DOSAGE... WITHOUT CONTINUOUS SUPERVISION.
Trew

R36 PEDATROL
–new concept in pediatric dosage control... 50ml. chamber in 10cc. segments.



pioneering parenterals for a quarter century

Carl Walter, M.D. (seated), is introduced to 600 hospital administrators by James D. Lierman, director, Hospital Division, Johnson & Johnson, at a luncheon held during opening of the company's new Eastern Surgical Dressings Plant at New Brunswick, N.J. Dr. Walter's talk on "Hospital Infections and How to Deal with Them," was heard by hospital personnel from New Jersey, New York, Pennsylvania and Connecticut.

TRADE TOPICS Continued

Laboratories. Mrs. LeMay replaces Dorothy Stiebling, who retired. Susan E. Keller has been named assistant editor.

* * *

Arthur S. Deter, M.D.—has been named senior editor of the scientific information division, Eaton Laboratories. He will assist Rolland J. Main, M.D., director of the division, with two Eaton publications: *Medical Director's Notebook*, and a new publication, also for physicians.

* * *

True E. Read—has been named special field representative, Pioneer Rubber Co. Mr. Read was an assistant sales manager for McKesson & Robbins, Inc. before joining Pioneer. He had been stationed in Cleveland for the past two years.

* * *

Beckman Instruments' Scientific Instruments Division—has announced appointment of William S. Gallaway, Ph.D., as senior physicist. Dr. Gallaway, formerly supervisor of infrared laboratory instrument applications, will supervise exploratory research into advanced types of analytical instrumentation for scientific, industrial, and medical laboratories.

* * *

Clayton P. Whipple — has been appointed director, research and development, Massillon Rubber Co. He was formerly with U. S. Rubber Co. and Sun Rubber Co.

* * *

Glenn Werly—is new Eastern regional manager, Ohio Chemical & Surgical Equipment Co. **Denny Cosgrove**, assistant Gas Sales manager, succeeds Mr. Werly as Gas Sales manager.

* * *

George B. Stone—has been named general manager, J. B. Roerig & Co., division of Chas. Pfizer & Co., Inc.

* * *

James F. Ryley—succeeds **Edwin J. Rhein,** who is retiring, as manager, Scientific Sales Division, Kimble Glass Co.

an incomparable protectant
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Dr. Vane Hoge to Direct Chicago Hospital Council

Vane M. Hoge, M.D., has retired as assistant surgeon general, U.S. PHS, and will become executive director, Hospital Planning Council for Metropolitan Chicago, on September 15. The Council, formed earlier this year, is studying hospital distribution, needs, and service requirements in the Chicago area.

Jack C. Haldeman, M.D., succeeds Dr. Hoge as assistant surgeon general. Dr. Haldeman was previously deputy to chief, U. S. PHS Division of Hospital and Medical Facilities, which administers Hill-Burton planning and programming.

Deadlines Announced For NFIP Fellowships

September 1 and December 1 have been announced as the current deadlines for applications to the National Foundation for Infantile Paralysis for fellowships available to personnel in medical and associated fields.

Grants are available for the following: study to prepare for instructional and administrative positions in physical therapy and occupational therapy; physical therapy travelships; scholarships providing basic education in physical therapy or medical social work; and short courses in care of the polio patient.

Financial support varies according to previous education, professional experience, marital status, and number of dependents. For a full academic program, tuition and fees are allowed. For other programs, a sum not to exceed $1,250 per year, including tuition, is provided.

Further information may be obtained from: Division of Professional Education, National Foundation for Infantile Paralysis, 301 E. 42nd St., New York 17, N.Y.

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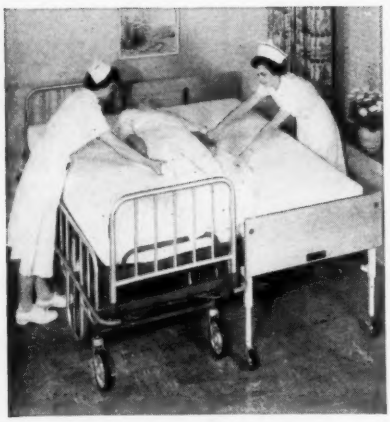

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